

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 5792

1. PLACE OF DEATH:

County.....
 City or town..... Rural Solley Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 2 yrs.
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Md County.....
 City or town..... Rural Solley Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... Vein Point Beach
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

George J. Berg.

3. (b) Social Security Number

4. Sex M. 5. Color or race W. 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Mathilde Riedel7. Birth date of deceased (mo., day, yr.) Nov. 5, 1895 6. (c) If alive, give age..... years8. AGE: Years 52 Months..... Days..... If less than one day..... hrs. min.9. Birthplace..... Germany.
(Town, county, and state)10. Usual occupation..... Baker

11. Industry or business

12. Name..... Adams Berg.13. Birthplace..... Germany14. Maiden name..... ?15. Birthplace..... ?16. Informant..... Mrs Mathilde BergAddress..... Solley Md. Vein Point Beach17. Burial (Burial, cremation, or removal, which?) Date thereof 6-8-48
(month) (day) (year)Cemetery or crematory..... Sacred HeartLocation..... German Hill Rd.18. Funeral director..... John B. MoranAddress..... 13000 E. Balt. St.19. June 7 19 48 A. W. H. H. H.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 5 19 48 at 2 a. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15 19 48 to June 5 19 48 and that I last saw him alive on June 4 19 48Immediate cause of death..... Coronary artery disease
by lungs & liver
general arteriosclerosis

DURATION

Nov. 1947

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Coronary a. & Hep
panc. Date of op. Nov. 1947Autopsy results..... see autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE..... Mrs. H. Phillips M. D. or otherAddress..... 3307 Edmondson Date signed..... 6-7-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of
birth date shown on:

FILE NO. G 116 JUN 17 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

5793

Reg. Dist. No. 5793

1. PLACE OF DEATH:

County anne arundel
City or town Blaugney station
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 or 3 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution? not at all

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County anne arundel
City or town Chesney
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war no

3. (a) FULL NAME

Walter Boze

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male negro married

B. (b) Name of husband or wife Caroline Conter Spragg Boze

Mar. 6 6. (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) Mar. 6, 1874 1873

8. AGE: Years Months Days If less than one day
74 7/5 Mar 0 hrs. min.

9. Birthplace Calvert County
(Town, county, and state)

10. Usual occupation farmer

11. Industry or business

12. Name Joseph Boze

13. Birthplace Calvert County

14. Maiden name Priscilla Waters

15. Birthplace Calvert County

16. Informant Wesley Conter

Address private ind.

17. Burial Date thereof 6-11-48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Halls Creek

Location Calvert

18. Funeral director P. E. Sewell

Address Prince Frederick Md

19. 6-9 19 48 H. H. Ward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8 19 48 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 30 19 48 to June 8 19 48
and that I last saw him alive on June 4 19 48

Immediate cause of death cerebral hemorrhage

Due to arteriosclerosis

Due to hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

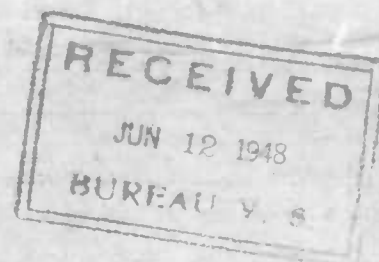
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Emil H. Wilam, M.D. M. D. or other
Address Lottman Md Date signed 6/8/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of MARYLAND STATE DEPARTMENT OF HEALTH
age shown on:
MIM No. G 116 AUG 4 - 1948 CERTIFICATE OF DEATH

2411 N. Charles St., Baltimore

93d

5794

Reg. Dist. No. 21

1. PLACE OF DEATH:

County *A. A.*
City or town *Annapolis Md.*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md.* County *A. A.*City or town *Annapolis Md.*
(If outside city or town limits, write RURAL and give nearest town)Street No. *1007 Poplar Ave*
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Laura Virginia Boteler

3. (b) Social Security Number

4. Sex

F.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

William W. Boteler

7. Birth date of deceased (mo., day, yr.)

Nov 20th 1898

6. (c) If alive, give age years

8. AGE:

Years

69

Months

70

Days

6

If less than one day

28

hrs.

min.

9. Birthplace

A. A. Co Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

Unknown

13. Birthplace

MOTHER

14. Maiden name

Unknown

15. Birthplace

16. Informant

Mrs John E. Pettebone

Address

1007 Poplar Ave Annapolis Md.

17. Burial

Burial

Date thereof

June 20th 48
(month) (day) (year)

Cemetery or crematory

Cedar Bluff

Location

Annapolis Md.

18. Funeral director

John M. Taylor & Son

Address

Annapolis Md.

19. Date

June 18 19 48
(To be rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *June 16 19 48* at *D*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 7 19 48 to *June 16 19 48*and that I last saw him alive on *June 16 19 48*

Immediate cause of death

Cerebral Hemorrhage

DURATION

Due to

Hypertensive Cardiovascular

Due to

Chronic

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address *Annapolis Md.* Date signed *6/17/48*

RECEIVED

JUN 19 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Under correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

5795

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Anne Arundel
 City or town..... Annapolis
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 2 1/2 hours
 Hospital, institution, or street address where death occurred:
Annapolis Emergency
 How long in hospital or institution?..... 2 1/2 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)
 State..... Maryland County..... Anne Arundel
 City or town..... Pasadena P.O.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... Mountain Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Norman Brantley

3. (b) Social Security Number

4. Sex..... male 5. Color or race..... negro 6. (a) Single, married, widowed, or divorced..... married

6. (b) Name of husband or wife..... Annie Bell 6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)..... 3/2/1925

8. AGE: Years..... 23 Months..... 3 Days..... 13 If less than one day..... hrs. min.

9. Birthplace..... Washington Co., Ga.
 (Town, county, and state)

10. Usual occupation..... Laborer

11. Industry or business.....

12. Name..... Julian Thomas

13. Birthplace..... Ga.

14. Maiden name..... Sady Brantley

15. Birthplace..... Ga.

16. Informant..... Sady Brantley

Address..... Pasadena P.O.

17. Burial Date thereof..... 6/18/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Mt Calvary

Location..... A. A. G. End

18. Funeral director..... Isaiah S. Brown & Son

Address..... 108 W. Montgomery St.

19. 6/16 19 48 R. B. Hedrick
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 15, 19 48 at 9:00 P. M.

21. I CERTIFY that death occurred on the date above stated Postmortem Examination
June 15, 1948

Immediate cause of death..... Second + Third degree Burns

Due to.....

Due to.....

Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... accident Date of..... 6-15-48

Where did injury occur?..... near Annapolis (City or town) A. H. Maryland (State)

Injured at home, farm, industry, public place (where?)..... F. P. Ashers Plant

Means of injury..... clothing caught fire Injured at work?..... yes

23. SIGNATURE..... John M. Caffy, M.D. M. D. or Examiner

Address..... Annapolis, Md. Date signed..... 6-15-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The coroner's age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

5796

Reg. Dist. No. 28

1. PLACE OF DEATH:

County Anne Arundel
 City or town Crownsville, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 days
 Hospital, institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.
 How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County (Baltimore)
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1505 N. Stricken
 (If rural, give LOCATION)
 2.(a) If veteran, name war ☒

3. (a) FULL NAME

JAMES BARRETT

3. (b) Social Security Number

4. Sex

Male

5. Color or race

Negro

6. (a) Single, married, widowed, or divorced

?

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

1899

8. AGE:

Years

Months

Days

If less than one day

54/9

?

?

hrs.

min.

9. Birthplace

Jamaica B.W.I.

(Town, county, and state)

10. Usual occupation

Seaman

11. Industry or business

12. Name

James Brown

13. Birthplace

Jamaica B.W.I.

14. Maiden name

Francis Vance

15. Birthplace

Jamaica B.W.I.

16. Informant

Hospital Records

Address

Crownsville, Maryland

17. Burial

(Burial, cremation, or removal, which?)

Date thereof

June 13, 1948

Cemetery or crematory

Mt. Calvary

Location

Brooklyn

18. Funeral director

W. Brooks Ruggles

Address

1463 N. Carey St.

19.

6/12 1948

19

S.W. Hedrick

(Date rec'd by registrar)

P.W. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10th 19 48 at 2:30P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 5th 19 48 to June 10th 19 48and that I last saw him alive on June 10th 19 48

Immediate cause of death

Myodegeneratio cordis

DURATION

Known to us since 6/5/48

Due to

Due to

Other conditions

Senile Psychosis

Known to us since 6/5/48

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE

Jacob H. Hester M.D.

M. D. or other

Address

Crownsville, Md.

Date signed 6/10/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of
birth date shown on:

FHM No. G 116 JUL 8 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

5797

20

1. PLACE OF DEATH:

County.....

City or town.....
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....

City or town.....
(If outside city or town limits, write RURAL and give nearest town)

Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Washington Brown

3. (b) Social Security Number

4. Sex..... 5. Color or race..... 6. (a) Single, married, widowed, or divorced.....

Male..... Col..... Widowed.....

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.).....

8. AGE:..... Years..... Months..... Days..... It less than one day..... hrs. min.

9. Birthplace.....
(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. (Burial, cremation, or removal) Which?..... Date thereof.....

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. (Date rec'd by registrar).....

Registrar.....

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 19..... at.....

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....

and that I last saw him alive on.....

Immediate cause of death.....

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RECEIVED

JUL 2 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 23

1. PLACE OF DEATH:

County Anne ArundelCity or town Harmon
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 yrHospital, institution, or street address where death occurred:
Dorsey Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Anne ArundelCity or town Harmon
(If outside city or town limits, write RURAL and give nearest town)Street No. Dorsey Rd.
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Mary Helen Burley

3. (b) Social Security Number

none4. Sex Female5. Color or race col6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife

8. (c) If alive, give age — years7. Birth date of deceased (mo., day, yr.) Sept 1 18888. AGE: Years 19 Months 9 Days 2 If less than one day
hrs. min.9. Birthplace Dorsey Rd.
(Town, county, and state)10. Usual occupation confiscator

11. Industry or business

12. Name Tacumak Burley13. Birthplace Anne Arundel Co Md14. Maiden name Edna Johnson15. Birthplace Anne Arundel Co Md16. Informant Rosie ChaseAddress Harmon Md RFD17. Burial Date thereof June 11 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Saint RestLocation Harmon, Md.18. Funeral director Mrs Katie R. WilliamsAddress 322 N Schroeder St19. June 5 1948 Caldwell Woodruff
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 1948, at 7 P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1947 to June 3 1948and that I last saw her alive on June 3 1948Immediate cause of death carcinoma ofbreast & generalcardiacDue to myocardialinfarctionDue to hypertensionOther conditions —

(Include pregnancy within 3 months of death)

Major findings of operations —Date of op. —Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —Where did injury occur? — (City or town) (County) (State)Injured at home, farm, industry, public place (where?) —Means of injury — Injured at work? —23. SIGNATURE W. B. BrumbyAddress Elbridge Date signed 6/11/48

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
JUN 10 1948
BUREAU V. 8.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH:

County Anne ArundelCity or town Fort George G Meade, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 hours

Hospital, institution, or street address where death occurred:

Station HospitalHow long in hospital or institution? 2 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Tennessee County HardinCity or town Hamburg
(If outside city or town limits, write RURAL and give nearest town)Street No. Post Office
(If rural, give LOCATION)

2. (a) If veteran, name war..... ✓

3. (a) FULL NAME

PAMELA DIANE CALHOUN

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

New born

8. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) 0537 hrs 30 June 1948

8. (c) If alive, give age..... years

8. AGE: Years Months Days If less than one day
1 hrs. 48 min.9. Birthplace Sta Hosp Fort Geo G Meade, Md.
(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

FATHER 12. Name Guy Robert Calhoun13. Birthplace MississippiMOTHER 14. Maiden name Maxine Love15. Birthplace Tennessee16. Informant Mrs Maxine Calhoun
Address 20 Victoria Road, Balto, Md.17. Burial Date thereof 2 July 48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Post CemeteryLocation Fort George G Meade, Maryland18. Funeral director Capt Norman Moore, Chaplain CorpsAddress Fort George G Meade, Maryland19. 30 June 48 19. JAMES N. GOERGER, Capt., MSc
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 June 1948 at 0725 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

30 June 1948, to 19
and that I last saw him alive on 30 June 1948Immediate cause of death Premature birth DURATION 2 hrs.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results No autopsy performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. M. Foster Capt MScHENRY M. FOSTER, Capt M, D. of ArAddress Ft Geo G Meade, Md. Date signed 30 June 48

RECEIVED

JUL 3 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

20

1. PLACE OF DEATH:

County Q. Q.City or town Riva South River
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 hours

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Washington D.C. County D.C.City or town Washington D.C.
(If outside city or town limits, write RURAL and give nearest town)Street No. 405 Gallatin St NW
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Robert Cameron

3. (b) Social Security Number

4. Sex

Male

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Aug 15th 1927

8. AGE:

Years 20 Months 10 Days 12 If less than one day
hrs. min.

9. Birthplace

Washington D.C.
(Town, county, and state)

10. Usual occupation

Plumbers Helper

11. Industry or business

Wallis Cameron

12. Name

Washington D.C.

13. Birthplace

Eva Myers

14. Maiden name

Va.

15. Birthplace

Mrs Eva Cameron

16. Informant

405 Gallatin St NW Washington

17. Burial

June 30th 1948
(Burial, cremation, or removal. Which?)

18. Cemetery or crematory

Arlington National

19. Location

Washington D.C.

20. Funeral director

W.H. Hentemann

21. Address

5732 Georgia Ave Washington D.C.

22. Date

June 28 1948
(Date rec'd by registrar)

23. Registrar

Edward Colburn

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 27 1948 at 2⁵⁵ P.M.21. I CERTIFY that death occurred on the date above stated: Post-mortem ExaminationJune 27 1948

Immediate cause of death

Drowning

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 6-27-48Where did injury occur? Riva D.C. Maryland
(City or town) (State)Injured at home, farm, industry, public place (where?) South RiverMeans of injury fell or dove off boat Injured at work? no

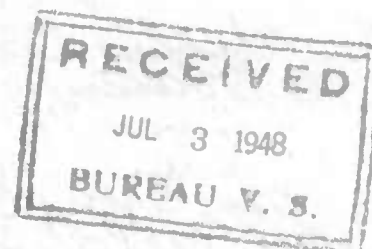
23. SIGNATURE

John M. Caffey M.D. medical Examiner
Address Annapolis, Maryland Date signed 6-28-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5801

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne ArundelCity or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:

Emergency HospitalHow long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne ArundelCity or town Crownsville, Post Office
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) if veteran, name war

3. (a) FULL NAME

LEMUEL WARD CECIL

3. (b) Social Security Number

4. Sex MALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced SINGLE

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) May 23, 1867 6.(c) If alive, give age years8. AGE: Years 81 Months 1 Days 30 if less than one day hrs. min.9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name James Cecil13. Birthplace Baltimore14. Maiden name Elizabeth Gosnell15. Birthplace Baltimore16. Informant Mrs Edward CecilAddress Crownsville, Post Office, A.A. Col Md17. Burial Date thereof July 21, 48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. James CemeteryLocation Chesterfield, A.A. Co., Maryland18. Funeral director Ben L. Hopping and SonAddress 170-172 West St. Annapolis, Md19. July 21 19 48
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20 19 48 at 3:20 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 19 48 to June 19 19 48 and that I last saw him alive on June 20 19 48Immediate cause of death Cerebral Thrombosis DURATIONDue to Atherosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

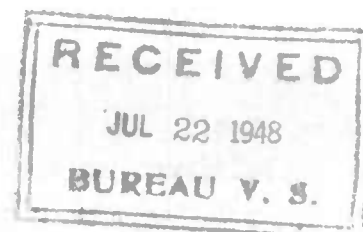
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John Hart M. D. or otherAddress Crownsville, Md Date signed 7/21/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County A. A. Md.
 City or town Annapolis Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

Emergency Hosp

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County A. A.

City or town Plewa
 (If outside city or town limits, write RURAL and give nearest town)

Street No.
 (If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Engene P. Childs

3. (b) Social Security Number

4. Sex

Male

5. Color or race

W

6. (a) Single, married, or divorced

Married

8. (b) Name of husband or wife

Dryden Hodges Childs

7. Birth date of

deceased (mo., day, yr.)

6. (c) If alive, give age

Oct 20th 1882

8. AGE:

Years

Months

Days

If less than one day

65721

hrs.

min.

9. Birthplace

A. A. Co Md.
(Town, county, and state)

10. Usual occupation

Lawyer

11. Industry or business

FATHER

12. Name

Nathan Childs

13. Birthplace

A. A. Co Md.

MOTHER

14. Maiden name

Margaret Hardisty

15. Birthplace

A. A. Co Md.

16. Informant

Engene M. Childs

Address

River A. A. Co Md.

17. Burial

(Burial, cremation, or removal, which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

All Hallows Conit

Location

Danversville Md.

18. Funeral director

Address

John M. Taylor, SonAnnapolis Md.

19. June 12 19 48

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 19 48 at 3:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 4 19 48 to June 10 19 48and that I last saw him alive on June 10 19 48

Immediate cause of death

Acute hemorrhagic stroke
Paralytic & a

DURATION

Stroke
3 days

Due to

Due to

Other condition

Acute Enteric Colitis
Cause unknown

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

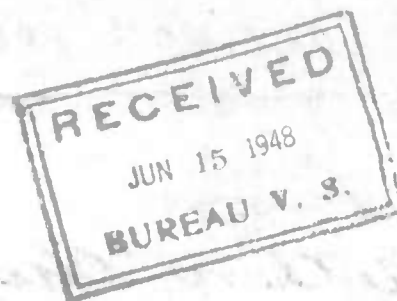
Means of injury Injured at work?

23. SIGNATURE

George C. Borel

M. D. or other

Address Annapolis Md. Date signed 6-11-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH:

County A. A.
City or town Jessups, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month
Hospital, institution, or street address where death occurred:
Md. House of Correction
How long in hospital or institution? 7 days in Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County A. A.
City or town Jessups
(If outside city or town limits, write RURAL and give nearest town)
Street No. No home
(If rural, give LOCATION)
2(a) If veteran, name war U.S.M.C. World War 1

3. (a) FULL NAME

John Cludray

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Separated

6. (b) Name of husband or wife Unknown

7. Birth date of deceased (mo., day, yr.) (Not known) 1884 6. (c) If alive, give age 4 years

8. AGE: Years 64 Months 0 Days 0 If less than one day 0 hrs. 0 min.

9. Birthplace El Paso, Texas
(Town, county, and state)

10. Usual occupation None

11. Industry or business None

12. Name Not known

13. Birthplace " "

14. Maiden name Not known

15. Birthplace " "

16. Informant Md. House of Correction

Address Jessups, Maryland

17. Burial Date thereof June 18-48
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Cherry Hill

Location Jessups Md

18. Funeral director Harry D. Colquhoun

Address Jessups Md

19. June 17 1948 Clara Haskup
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9 19 48, at 11:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 5 19 48, to June 9 19 48.

and that I last saw him alive on June 9 19 48.

Immediate cause of death Congestive Heart Failure.

DURATION 7 days.

Due to Chronic valvular heart disease.

Due to (Mitral insufficiency and Aortic Stenosis.) years

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John A. Clark, M.D.

M. D. or other M. D.

Address Jessups, Maryland Date signed 6/10/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1881
79
1948

RECEIVED

JUL 7 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

5804

Reg. Dist. No. 20

1. PLACE OF DEATH

County DealCity or town Deal
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infant, give residence of mother)

State Ind. County DealCity or town Deal
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

Estella Coates

3. (b) Social Security Number

5. Color or race

6. (a) Single, married, widowed, or divorced

Widow6. (b) Name of husband or wife Benjamin Coates7. Birth date of deceased (mo., day, yr.) Sept. 11 1884

6. (c) If alive, give age _____ years

8. AGE: Years 63 Months 8 Days 22 If less than one day _____ hrs. _____ min.9. Birthplace Ind. Co.
(Town, county, and state)10. Usual occupation Domestic

11. Industry or business

12. Name Mac. Broth13. Birthplace Calvert Co.14. Maiden name Jessie Harsey15. Birthplace Calvert16. Informant Benjamin CoatesAddress 1008 7th St. N.E. Washington17. Benjamin Date thereof June 13/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Int. UnionLocation Lotham, Ind.18. Funeral director J. B. JohnsonAddress 62 48 St. Clayton19. 6-2-48 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1 1948 at 5:30 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Dec. 27 1947 to June 1 1948and that I last saw him alive on May 10 1948Immediate cause of death carcinoma of colon

DURATION

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

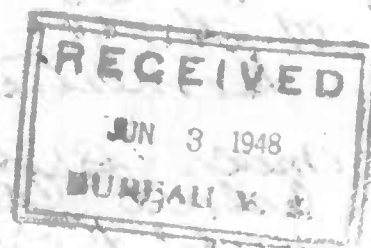
Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Emil H. Wilson, M.D.

M. D. or other

Address Lotham, Ind. Date signed 6-2-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne ArundelCity or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 15Hospital, institution, or street address where death occurred:
808 Spa Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne ArundelCity or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)Street No. 808 Spa Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Carcella Cook

3.(b) Social Security Number

214-05-0737

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male Negro Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 16, 19068. AGE: Years Months Days If less than one day
41 6 2 hrs. min.9. Birthplace Eastport
(Town, county, and state)10. Usual occupation Labor

11. Industry or business

12. Name Mackus Cook13. Birthplace Calvert County14. Maiden name Joanne Richardson15. Birthplace Calvert County16. Informant Thomas E RichardsonAddress Parole Md.17. Burial Date thereof 6 22 48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory AsburyLocation Smithville18. Funeral director William Reese 11Address 108 Washington St19. June 21 1948
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1948 at 7:40 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 8 1948 to June 18 1948
and that I last saw him alive on 6-15-48 1948Immediate cause of death Cerebral Hemorrhage

OURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. T. Cook M. D. or otherAddress 10 Carroll Date signed 6-18-48

RECEIVED
JUN 23 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

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CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County ANNE ARUNDEL

City or town EASTPORT
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

17 EASTERN AVENUE

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County A.A.Co.

City or town EASTPORT
(If outside city or town limits, write RURAL and give nearest town)

Street No. 17 EASTERN AVE.
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

ALVA. W. CORNER

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife Thomas J. Corner

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DECEMBER 31ST 1887

8. AGE:

Years

Months

Days

It less than one day

60

5

25

hrs.

min.

9. Birthplace MARYLAND
(Town, county, and state)

10. Usual occupation None

11. Industry or business

12. Name GEORGE W. JONES

13. Birthplace Jones Malboro - Md.

14. Maiden name EMMA PINKNEY WALES

15. Birthplace A. A. Co. Md.

16. Informant MRS. FRANK CORNER

Address CHARLES ST. ANNAPOLIS

17. BURIAL Date thereof 6/28/48
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory ST. MARGARET'S CEMT.

Location A. A. Co., Md.

19. Funeral director John M. Taylor + Son

Address ANNAPOLIS

19. June 28, 1948
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25, 1948 at 3P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1, 1948 to June 25, 1948

and that I last saw him alive on June 25, 1948

Immediate cause of death

Myocardial Infarction
Due to Myocardial Ischemia

DURATION

Several years

Due to

Arteriosclerosis (hypertension)

Other condition

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

24. SIGNATURE George C. Bond

Address ANNAPOLIS

Date signed 6-27-48

MARGIN RESERVED FOR BINDING

I

9-45-15M

VS 415

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 29 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 Hrs.
Hospital, institution, or street address where death occurred:
Emergency Hospital
How long in hospital or institution? 6 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel
City or town Cedar Park, Nr. Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 726 Glenwood St.
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME

ROBERT JOSEPH CRUTCHLEY

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single
6.(b) Name of husband or wife.....
6.(c) If alive, give age..... years
7. Birth date of deceased (mo., day, yr.) January 26, 1948
8. AGE: Years 0 Months 4 Days 8 If less than one day.....hrs.min.

9. Birthplace Annapolis, Anne Arundel Co., Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Ridgley W. Crutchley
13. Birthplace Annapolis, Maryland
MOTHER 14. Maiden name Mary E. Little
15. Birthplace Pa;

16. Informant Mr. Ridgley W. Crutchley
Address 726 Glenwood St. Cedar Park, Maryland

17. Burial Date thereof June 5, 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory St. Mary's Cemetery
Location Annapolis, Maryland

18. Funeral director Ben L. Hopping and Son
Address 170-172 West St. Annapolis, Maryland

19. June 5 19 48
(Date rec'd by registrar) Registrar [Signature]

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4 19 48 at 3:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 19 48 to June 4 19 48 and that I last saw him alive on June 4 19 48

Immediate cause of death fatal pneumonia
pneumonia & pleurisy

DURATION 3 days

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations conformation of above diagnosis Date of op.

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE S. Borsuch, M.D. M. D. or other

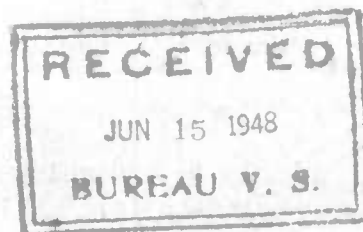
Address Annapolis, Md Date signed 6/5/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Boardman



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Anne ArundelCity or town Laurel
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Five seconds

Hospital, institution, or street address where death occurred:

B.O. Railroad Track - 1/2 from Laurel

How long in hospital or institution?

3. (a) FULL NAME

John Davenport4. Sex W.5. Color or race Colored6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 15, 1896.8. AGE: Years 52 Months 4 Days 25 If less than one day

..... hrs. min.

9. Birthplace Lexington, Kentucky.

(Town, county, and state)

10. Usual occupation Freeman, Porter11. Industry or business B. & O. Railroad Company.12. Name STEVEN DAVENPORT13. Birthplace Ky.14. Maiden name ELIZABETH.15. Birthplace Ky.16. Informant C.E. Hicks, B. & O. Gen. Claims A.E.T.Address BALTIMORE, Md.17. BURIAL Date thereof JUNE 14, 1948.

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory WHITE RIDGE CEMETERYLocation EATONTOWN, N.J. (Monmouth County)18. Funeral director J. ARTHUR WALTERS FUNERAL HOMEAddress 505 WASHINGTON BLVD., LAUREL, Md.19. June 10 19 48 Olara K. K. K.

(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State New Jersey County MonmouthCity or town Asbury Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1010 - Lookman Ave.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

709-09-4204.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 19 48 at 12:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... To..... 19.....

and that I last saw h..... alive on..... 19.....

Immediate cause of death.....

.....

.....

Due to.....

.....

Due to.....

.....

Other conditions.....

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JUL 7 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne ArundelCity or town Eastport
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne ArundelCity or town Eastport
(If outside city or town limits, write RURAL and give nearest town)Street No. 529 Second
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Grace O. Deale

3. (b) Social Security Number

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Peyton A Deale7. Birth date of deceased (mo., day, yr.) Feb 29 1885 6. (c) If alive, give age _____ years8. AGE: Years 63 Months 4 Days 1 If less than one day _____ hrs. _____ min.9. Birthplace A. A. Co. Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business House wife12. Name Robert Price13. Birthplace A. A. Co. Md.14. Maiden name Emma Avery15. Birthplace A. A. Co. Md.16. Informant Peyton A. DealeAddress 529 Second St. Eastport Md.17. Burial Date thereof June 6 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Glen Haven MemorialLocation Glen Burnie Md.18. Funeral director John M. Taylor & SonAddress Annapolis Md.19. June 4 1948 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 1948 at 2:00 P.21. I CERTIFY that death occurred on the date above stated Postmortem Examinationwith a blood sample taken June 3 1948Immediate cause of death Suicideby carbon monoxide

gas

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 6-3-48Where did injury occur? Eastport (City of town) A. A. (County) Md. (State)Injured at home, farm, industry, public place (where?) at homeMeans of injury illuminating gas Injured at work? no23. SIGNATURE John M. Claffy MD Deputy Medical ExaminerAddress Annapolis Md. Date signed 6-3-48

MARGIN RESERVED FOR BINDING

I

VS A15 9-45:15M T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 7 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County... Anne Arundel
 City or town... Point Pleasant - Brooklyn 25
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....

City or town.....
 (If outside city or town limits, write RURAL and give nearest town)Street No. Laurel
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Mrs. Sarah Francis Duesen

3. (b) Social Security Number

4. Sex

F.

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Joseph Duesen

7. Birth date of

deceased (mo., day, yr.)

January - 29 - 18876. (c) If alive, give age 68 years

8. AGE:

Years

Months

Days

If less than one day

601016

..... hrs.

..... min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

Joseph Keltay

13. Birthplace

Baltimore, Md.

MOTHER

14. Maiden name

Laura Brooks

15. Birthplace

Baltimore, Md.

16. Informant

Address

Joseph Duesen (husband)Point Pleasant - P.O. Brooklyn 25

17.

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Burial

Date thereof

6/18/48

Location

Cedar Hill

18. Funeral director

Address

a. a. Co. Md.William Cook Inc.

19.

(Date rec'd by registrar)

19

6/1648Rev. BedardDr Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1948 at 12:5 A. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1946 to June 14 1948 and that I last saw her alive on 6/14/48 1948

Immediate cause of death

Myocardial insufficiency

DURATION

3 years

Due to

suppurative nephritis3 y

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE

Ernest H. Fairbank, M.D.

M. D. or other

Address Isle of Buena Vista, Md. Date signed 6/15/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. **3**

1. PLACE OF DEATH:

County **A.A.CO.**City or town **Rock View Beach**
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State **Md** CountyCity or town **Baltimore**
(If outside city or town limits, write RURAL and give nearest town)Street No. **321 Whitridge Avenue**
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

IDA MATILDA ESCHENBACH

3. (b) Social Security Number

214-24-3346

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife **William C. Eschenbach**6. (c) If alive, give age **56** years7. Birth date of deceased (mo., day, yr.) **January 10, 1902**

8. AGE:

Years

Months

Days

If less than one day

46**5****20**

hrs.

min.

9. Birthplace

Penna.

(Town, county, and state)

10. Usual occupation **Pemco Plant**

11. Industry or business

12. Name **Charles W. Baker**13. Birthplace **Baltimore, Md.**14. Maiden name **Ida B. Baker**15. Birthplace **Baltimore, Maryland**16. Informant **William C. Eschenbach**Address **321 Whitridge Avenue - 18**17. **Burial** Date thereof **6/29/48**
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory **Baltimore National**
Baltimore, Md.

Location

18. Funeral director **HENRY SANDER & SONS, INC.**Address **NORTH AVE & BROADWAY**19. **June 28 1948** a.w. **Edmund**
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **June 25 1948** at **11:55 A.M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 24 1948 to **June 25 1948**and that I last saw him alive on **June 24 1948**Immediate cause of death **Cerebral Hemorrhage** DURATIONDue to **Hypertension** **1 year**

Due to

Other conditions **Arteriosclerosis** **1 year****Cirrhosis Liver**
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE **J. Brady Smith M.D.** M. D. or otherAddress **Quintessence Beach, Md.** Date signed **6/25/48**

MARGIN RESERVED FOR BINDING

VS A45 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

D. Basile

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

5812

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH.

County Anne Arundel
City or town Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel
City or town Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2 Southgate Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

George T. Feldmeyer

3.(b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widower

6.(b) Name of husband or wife

Emma B. Feldmeyer

7. Birth date of deceased (mo., day, yr.)

Oct 28-1859

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

8878

hrs.

min.

9. Birthplace

Annapolis Md.

10. Usual occupation

Retired (Dentist)

11. Industry or business

FATHER

12. Name

Gottlieb Feldmeyer

13. Birthplace

Germany

MOTHER

14. Maiden name

Dorothea Oberg

15. Birthplace

Germany

16. Informant

Miss Vieve Feldmeyer

Address

2 Southgate Ave Annapolis Md.

17. (Burial, cremation, or removal. Which?)

Burial

Date thereof

June 8-1948

Cemetery or crematorium

St Annes

Location

Annapolis Md.

18. Funeral director

John M. Taylor, Son

Address

Annapolis Md.

19. (Date rec'd by registrar)

June 8 1948

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 6

19

48 at 6 9 M

21. CERTIFY that death occurred on the date above stated; that I attended deceased from

May 25 1948 to June 6 1948and that I last saw him alive on June 6 1948

Immediate cause of death

Mycocarditis Chr with
Myocardial infarction

Dua to

Arteriosclerosis

Dua to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

George C. Boul

M. D. or other

Address

Annapolis Md.Date signed 6-7-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 9 1948

BUREAU V. S.

VS AJ5

9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE

WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: Anne Arundel Co.
Edison Island
 County Maryland
 City or town Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?:

2. USUAL RESIDENCE (HOME) OF DECEASED
 (For newborn infants give residence of mother)
Anne Arundel Co.
 State Maryland County Edison Island
 City or town
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME Freeman
Lloyd Ross Freeman

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Elizabeth
 7. Birth date of deceased (mo., day, yr.) March 7 - 1883 6. (c) If alive, give age _____ years
 8. AGE: Years 65 Months 3 Days 8 If less than one day _____ hrs. _____ min.

9. Birthplace Pocomoke - Md
 (Town, county, and state)

10. Usual occupation Lawyer

11. Industry or business Self Retired

12. Name Edward B. Freeman

13. Birthplace Norville Tenn

14. Maiden name Mrs. Lloyd

15. Birthplace Pocomoke - Md

16. Informant Mrs. Elizabeth Freeman

Address Edison Island, Md

17. Cremation Date thereon June 17, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Green Mount

Location Baltimore, Md

18. Funeral director William Cook, Inc.

Address 1017 St. Paul St

19. 6/16/48 28 DW. Hedrich
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/14/48 at 5:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1946, to 6/14/48

and that I last saw him alive on 6/14/48 19 48

Immediate cause of death Cardiac Failure

Due to Arteriosclerosis

Due to Endocarditis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Page Edmund M.D.

Address Edison Island, Md Date signed 6/15/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel
City or town Riversa Beach
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? not known
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 609 South Post St.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Raymond F. Gabriel

3. (b) Social Security Number

212-12-6730

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 23, 1917

8. AGE: Years 29 Months 5 Days 3 If less than one day hrs. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation Inspector

11. Industry or business American Can Co.

12. Name Walter Gabriel

13. Birthplace Philadelphia; Pa

14. Maiden name Pearl Philliss

15. Birthplace Baltimore, Md

16. Informant M. Walter Gabriel

Address 609 S. Post St.

17. Burial Date thereof 6/14/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Morland Memorial Park

Location Taylor Ave

18. Funeral director Howard N. Bright & Co.

Address 6009 Taylor Road

19. 6/3 XP AW Hedrick
(Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1, 1948 at 7:40 P.M.

21. I CERTIFY that death occurred on the date above stated (Was I attended by a physician?)

Postmortem Examination

and that I last saw him alive on June 1, 1948

Immediate cause of death

Acute Dilatation of Heart

Due to Heart

Due to sudden

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John M. Coffey, M.D. deputy medical examiner

Address Annapolis, Md. Date signed 6/11/48

MARGIN RESERVED FOR BINDING

VS A15 9-45:15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH *bc*
2411 N. Charles St., Baltimore *94a*
CERTIFICATE OF DEATH

5814

Reg. Dist. No. *21***1. PLACE OF DEATH:**

County *Prince Georges*
City or town *Fount Pleasant Beach, P.O. Pasadena*
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? *20 years*
Hospital, institution, or street address where death occurred: *Wharf Road*
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State *MD* County
City or town *Balto*
(If outside city or town limits, write RURAL and give nearest town)
Street No. *2128 Walbrook Ave*
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME*Joseph Goldstein***3. (b) Social Security Number**

4. Sex *Mr.* 5. Color or race *W.* 6.(a) Single, married, widowed, or divorced *Married*
6.(b) Name of husband or wife *Bessie L. Berman*
6.(c) If alive, give age *68* years
7. Birth date of deceased (mo., day, yr.) *Nov 28 1882*

8. AGE: Years *65* Months *6* Days *19* If less than one day
hrs. min.

9. Birthplace *Liverpool England*
(Town, county, and state)

10. Usual occupation *Retired Salesman*

11. Industry or business

12. Name *Mathew Goldstein*
13. Birthplace *London, England*

14. Maiden name *Sarah*

15. Birthplace *London England*

16. Informant *Mr. Bessie L. Goldstein*
Address *Fount Pleasant Beach, P.O. Pasadena MD*

17. *Burial* Date thereof *June 18/48*
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *Balto Hebrew Cemetery*
Location *Belair Road*

18. Funeral director *Sol Lewinman Bus*
Address *1124-26th North Ave*

19. *6/17/48* *Dr. Hedrich*
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH *June 16* 19*48* at *11:30* P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19... to 19...
and that I last saw him alive on 19...

Immediate cause of death *Coronary occlusion* DURATION *sudden*

Due to
Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide
Date of

Where did injury occur?
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE *Instal P. Pancher MD*
Address *Belair Road* Date signed *6/17/48*
M. D. or other

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH: Anne Arundel
County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 37 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 37 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... Maryland..... County.....
City or town..... Baltimore.....
(If outside city or town limits, write RURAL and give nearest town)
Street No..... 2302 Druid Hill Ave.
(If rural, give LOCATION)
2. (a) If veteran, name war.....

3. (a) FULL NAME

JAMES GROSS

3. (b) Social Security Number

4. Sex male
5. Color or race negro
6. (a) Single, married, widowed, or divorced single
6. (b) Name of husband or wife ----
6. (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) April 25, 1878
8. AGE: Years 70 Months Days It less than one day
..... hrs. min.

9. Birthplace..... Maryland
(Town, county, and state)
10. Usual occupation..... Laborer
11. Industry or business ----
12. Name William Gross
13. Birthplace Maryland
14. Maiden name Annie Chase
15. Birthplace Maryland

16. Informant..... Hospital Records
Address..... Crownsville, Md.

17. Burial Date thereof 6/27/48
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory..... Mt. Auburn
Location..... Baltimore, Md.

18. Funeral director..... George G. Kelson
Address..... 1303 Presstman St., Balto.

19. 6/25 48 E. J. Joyce Local
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 24 1948 at 11:10 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
May 18 1948 to June 24 1948
and that I last saw him alive on June 24 1948

Immediate cause of death..... General Arteriosclerosis
Known to us since 5/18/48

Due to.....

Due to.....

Other conditions..... Senile Psychosis
known to us since 5/18/48
(Include pregnancy within 3 months of death)

Major findings of operations.....
..... Date of op.

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
Means of injury..... Injured at work?

23. SIGNATURE..... Jacob M. Muncie
Crownsville, Md.
Address..... Date signed 6/24/48

RECEIVED

JUN 26 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

5816

Reg. Dist. No.

22

1. PLACE OF DEATH:

County Anne Arundel
City or town Gambrells
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County Anne Arundel
City or town Gambrells
(If outside city or town limits, write RURAL and give nearest town)
Street No. Crain Highway, R. 7W
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Joanne Hamilton

3. (b) Social Security Number

4. Sex

female

5. Color or race

negro

6. (a) Single, married, widowed, or divorced

—

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) June 8, 1948

8. AGE: Years Months Days If less than one day
21 hrs. 15 min.

9. Birthplace Gambrells, A. A. County, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name John H. Hamilton
13. Birthplace Chesterfield, Maryland

14. Maiden name Anna L. Wilson
15. Birthplace Gambrells, Md.

16. Informant Anna L. Hamilton
Address Gambrells, Md.

17. Burial Date thereof June 10, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Tabor Cemetery
Location Gambrells, Md.

18. Funeral director John H. Hamilton (Father)
Address Crain Highway, Gambrells, Maryland

19. June 10, 19 48
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9, 1948 at 9 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Postmortem Examination and that I last saw him alive on June 9, 1948

Immediate cause of death

Atelectasis

Due to

Respiratory failure

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

John M. Casey M.D. Deputy Medical Examiner
Address Annapolis, Md. Date signed 6-9-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Write correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 7 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No.

5817

28

1. PLACE OF DEATH:

County..... Anne Arundel
City or town..... Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... 11 mos. 22 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution?..... 11 mos. 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State..... Maryland..... County.....
City or town..... Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No..... 1322 North Bond Street
(If rural, give LOCATION)
2.(a) If veteran, name war..... World War I

3. (a) FULL NAME

DEMPSEY J. HARDY

3. (b) Social Security Number

4. Sex..... male
5. Color or race..... negro
6.(a) Single, married, widowed, or divorced..... married
6.(b) Name of husband or wife.....
6.(c) If alive, give age..... years
7. Birth date of deceased (mo., day, yr.)..... October 28, 1888
8. AGE: Years..... 59 Months..... 7 Days..... It less than one day..... hrs. min.

9. Birthplace..... North Carolina
(Town, county, and state)
10. Usual occupation..... Laborer
11. Industry or business.....
FATHER
12. Name..... Jack Hardy
13. Birthplace..... North Carolina
MOTHER
14. Maiden name..... Olive Joyner
15. Birthplace..... North Carolina

16. Informant..... Hospital records
Address..... Crownsville, Maryland
17. Burial..... Date thereof..... 6/14/48
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory..... Greenhill
Location..... North Carolina
18. Funeral director..... E. J. Joyce & Parker
Address..... Greenville, North Carolina
6/11/48
19. (Date rec'd by registrar)..... E. J. Joyce, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 11..... 19.. 48.. at 2:50 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
June 20..... 19.. 47..... to June 11..... 19.. 48.....
and that I last saw him alive on June 11..... 19.. 48.....

Immediate cause of death..... General Arteriosclerosis DURATION
known to us since Jan. 1948

Due to.....

Due to.....

Other conditions..... Schizophrenia, Paranoid Type
known to us since 6/20/47
(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury..... Injured at work?

23. SIGNATURE..... M. D. or other
Crownsville, Md.
Address..... Date signed 6/11/48

RECEIVED

JUN 14 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH:

County Anne Arundel
 City or town Annapolis, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 22 days
 Hospital, institution, or street address where death occurred:
U.S. Naval Hospital, Annapolis, Maryland
 How long in hospital or institution? 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Odenton A. A.
 City or town Odenton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name War _____

3. (a) FULL NAME

HARRIS, Henry Talbot

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Mildred HARRIS
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) January 15, 1902
 8. AGE: Years 46 Months 4 Days 19 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Maryland
 (Town, county, and state)
 10. Usual occupation Unemployed
 11. Industry or business _____
 12. Name Edward Harris Deceased
 13. Birthplace Md
 14. Maiden name Era (Unknown) Deceased
 15. Birthplace "

16. Informant Sgt. Richard Harris
4846 - 68th Ave. Hyattsville
Burial Date thereof 6/7/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Nichols Memorial
 Location Odenton Md.
 18. Funeral director William Cook Inc.
 Address 127 St. Paul St.
 19. June 7, 48 A. W. Hedrick
 (Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH 4 June 19 48 at 9:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-13-48 19 48 to 6-4-48 19 48
 and that I last saw him alive on 6-4-48 19 48

Immediate cause of death Chronic Rheumatic Heart Disease with Auricular Fibrillation DURATION _____

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results AS ABOVE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE F. H. THOMAS, JR., LT., MC., U.S.N.
 M. D. or other _____

Address U.S.N. Hospital, Annapolis, Md. Date signed 6-4-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No.

1. PLACE OF DEATH:

County Anne ArundelCity or town Odenton
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(Formerly born infants give residence of mother)

State Maryland County Anne ArundelCity or town Odenton
(If outside city or town limits, write RURAL and give nearest town)Street No. 5th Street

(If rural, give LOCATION)

2.(a) If veteran, name war RETIRED U.S. ARMY

3. (a) FULL NAME

Thomas Fleming Haughey

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Maria Haughey

7. Birth date of deceased (mo., day, yr.)

March 3, 18836. (c) If alive, give age 57 years

8. AGE:

Years

Months

Days

If less than one day

6536

.....hrs.min.

9. Birthplace

Arizona
(Town, county, and state)

10. Usual occupation

Retired U. S. Army

11. Industry or business

-

MOTHER FATHER

12. Name

Thomas C. Haughey

13. Birthplace

Ireland

14. Maiden name

Sarah Green

15. Birthplace

Kentucky

16. Informant

Mrs M. Haughey

Address

5th St Odenton Md

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof 6-12-48
(month) (day) (year)

Cemetery or crematory

Balto National

Location

Fredrick Road

18. Funeral director

Leo B. Cook

Address

1701-03 N Patterson Park Ave

19. Date

June 10, 1948

at

20

at

Medust

at

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at

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at

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at

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at

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at

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at

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at

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at

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at

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at

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 9, 1948, at 5 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Postmortem Examination June 9, 1948

Immediate cause of death

Acute cardiac failure

DURATION

Acute

Due to

Chronic myocarditis3 years

Due to

Cardiac asthma3 years

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

Address

John M. Coffey, M.D.
Annapolis, Md

Injured at work

Signature

Date signed

6-9-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 2/

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Emergency Hospital
How long in hospital or institution

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 24 Cornhill St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME
Emma Hobbs

3. (b) Social Security Number

4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Joseph Hobbs

7. Birth date of deceased (mo., day, yr.) March 4, 1877 6. (c) If alive, give age years

8. AGE: Years 71 Months 3 Days 25 It less than one day hrs. min.

9. Birthplace Annapolis, A.A. Co. Md.
(Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

FATHER 12. Name James Harris

13. Birthplace Md.

MOTHER 14. Maiden name Emily Johnson

15. Birthplace Md.

16. Informant Juanita Proctor

Address 24 Cornhill St Annapolis, Md.

17. Burial Date thereof July 3, 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St. Mary's

Location Annapolis, Md.

18. Funeral director J.B. Johnson

Address Annapolis, Md. 20, Box 462

19. July 3, 1948
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 29 June 1948 at 6:20 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 26 June 1948 to 25 June 1948 and that I last saw him alive on 19

Immediate cause of death acute intestinal obstruction DURATION 6 days

Due to Post-operative intestinal adhesions from previous operation performed many years ago for appendicitis

Other conditions (Time and place of operation not known)
(Include pregnancy within 3 months of death)

Major findings of operations 2-lumen middle l. obstructed by adhesions (old adhesions) Date of op. 28 June 48

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James H. Hester, M.D.

Address 53 Cornhill St Annapolis, Md. Date signed 2 July 48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 7 1948

BUREAU V. S.

Evidence for change of
age and birth date shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

FILE NO. G 116 JUL 9 1948 CERTIFICATE OF DEATH

Reg. Dist. No. 5821 21

1. PLACE OF DEATH

County A.A.
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Emergency Hosp.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md. County A.A.
City or town W. F. D.
(If outside city or town limits, write RURAL and give nearest town)
Street No. W. F. D.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Benjamin W. Hodges

3. (b) Social Security Number

4. Sex M. 5. Color or race W. 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Sept. 30, 1895 26. (c) If alive, give age 53 years

8. AGE: Years 53 Months 9 Days 7 If less than one day hrs. min.

9. Birthplace A.A. Co Md.
(Town, county, and state)

10. Usual occupation Postmaster at Ring Md.

11. Industry or business John J. Hodges

12. Name John J. Hodges

13. Birthplace A.A. Co Md.

14. Maiden name Ida Kent

15. Birthplace A.A. Co Md.

16. Informant C. Addison Hodges

Address Defence Highway A.A. Co Md.

17. Burial Date thereof July 2, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory All Hallows

Location Davidsonville Md.

18. Funeral director John M. Taylor, Son

Address Annapolis Md.

19. July 2, 1948
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30, 1948 at 12:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 30, 1947 to June 30, 1948 and that I last saw him alive on June 30, 1948.

Immediate cause of death Arteriosclerotic Cardiac Vascular Disease

Due to

Due to

Other conditions Cardiac Hypertrophy; Generalized Atherosclerosis
(Include pregnancy within 2 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Albert C. Anderson MD. M. D. or other

Address Annapolis, Md. Date signed 6/30/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 3 1948

BUREAU V. S.

Evidence for change of
name shown on: AA

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

5822

Reg. Dist. No. 29

FILE No. G 116 JUL 15 1948

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County H. A. C.
City or town Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10-1-47
Hospital, institution, or street address where death occurred: Crownsville State Hosp.
How long in hospital or institution? 10-1-47

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MD. County Horowitz
City or town Bishop
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war — ✓

3. (a) FULL NAME

Lanty

(probably nickname for "Arianta")

LIANNE HOLLAND

3. (b) Social Security Number

4. Sex

female

5. Color or race

C.

6. (a) Single, married, widowed or divorced

✓

6. (b) Name of husband or wife

William Holland

7. Birth date of deceased (mo., day, yr.)

1876

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

72

4

2

hrs.

min.

9. Birthplace

Bishop Md.
(Town, county, and state)
housewife

10. Usual occupation

11. Industry or business

William Holland

MOTHER
FATHER

12. Name

William Holland

13. Birthplace

Md.

14. Maiden name

Katherine Holland

15. Birthplace

Md.

16. Informant

Louis Marney (son)

Address

Bishop Md.

17.

Burial
(Burial, cremation, or removal. Which?)

Date thereof June 8, 1948
(month) (day) (year)

Cemetery or crematory

Location

near Berlin Md.

18. Funeral director

Address

James H. Stewart
Salisbury Md.

19.

6-6-48
(Date rec'd by registrar)

E. J. Jones
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-6-48 19 515 at 515

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-1-47 to 6-6-48
and that I last saw him alive on 6-5-48

Immediate cause of death

myodegeneratio
myodegeneratio

Due to

senile marasmus

Due to

senile psychosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

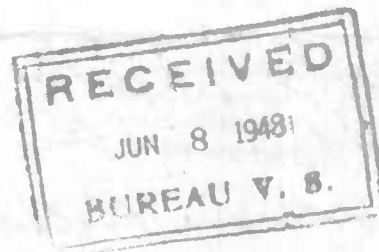
Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE

Jacob Maryniska M.D.
M. D. or other
Address..... Date signed.....

1948-61-6
72
1876



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate age and sex of deceased. Indicate cause of death clearly and legibly. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Claffy - 5823

Reg. Dist. No. 20

1. PLACE OF DEATH:

County... Ann Arundel
 City or town... Annapolis (Rural)
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md. County... ArundelCity or town... Edgewater
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

malecoloredsingle

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Edward Williamson
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1948 at 10¹⁵ P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Postmortem Examination
and that I last saw him alive on June 13 1948

Immediate cause of death

DURATION

Due to

Died of

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes fill in the following:

Accident, suicide, or homicide suicide Date of 6-13-48Where did injury occur? Edgewater, A.A. Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) at homeMeans of injury shot-gun Injured at work? no

23. SIGNATURE

M. D. or other

Address Annapolis, Md Date signed 6-16-48

RECEIVED

JUN 21 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

5824

93d

1. PLACE OF DEATH:

County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 days
Hospital, institution, or street address where death occurred:
Emergency Hospital
How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Rural - Edgewater
(If outside city or town limits, write RURAL and give nearest town)
Street No. Muddy Creek Rd.
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Larrah Ireland

3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced M

6. (b) Name of husband or wife Thomas Ireland

7. Birth date of deceased (mo., day, yr.) Jun 7, 1871 6. (c) If alive, give age 78 years

8. AGE: Years 76 Months 11 Days 27 It less than one day hrs. min.

9. Birthplace Anne Arundel Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name George W. Asquith

13. Birthplace A.A. Co., Maryland

14. Maiden name Mary V. Ireland

15. Birthplace A.A. Co. Maryland

16. Informant Mrs. Grace Adler

Address Edgewater Post office, A.A. Co. Md.

17. Burial Date thereof June 7, 48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hope Chapel Cemetery

Location Mayo Rd. Edgewater, Md.

18. Funeral director Ben L. Hopping and Son

Address 170-172 West St. Annapolis, Md.

19. June 7, 1948
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4, 1948 at 11:53 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1947 to June 4, 1948
and that I last saw him alive on June 3, 1948

Immediate cause of death

Cerebral hemorrhage

Due to Hypertension

Due to Arteriosclerotic cardiovascular disease

Other conditions dissecting

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. Peyton Ritchie, M.D.
M. D. or other

Address Annapolis, Md. Date signed June 7, 1948

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH CONFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 8 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 5825 20

1. PLACE OF DEATH:

County Anne Arundel
City or town Drury Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Drury Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

John Edward Johnson

3. (b) Social Security Number

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Widowed
6.(b) Name of husband or wife Snack Jane Evans
6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Feb 7. 1885

8. AGE: Years 63 Months 4 Days 19 hrs. min.

9. Birthplace Mt. Zion
(Town, county, and state)

10. Usual occupation Seamstress

11. Industry or business

FATHER 12. Name John Henry Johnson
13. Birthplace Unknown

MOTHER 14. Maiden name Unknown
15. Birthplace Unknown

16. Informant Anne E. Johnson
Address Lothman

17. Burial, cremation, or removal. Where? Burial Date thereof June 30, 1948
(month) (day) (year)

Cemetery or crematory Drury Md.
Location D. A. Hardisty & Son

18. Funeral director Salisbury
Address 630 48 St. Clayton

19. (Date rec'd by registrar) 19 6/30 19 48 Registrar Reginald

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26 19 48 at 7A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 2nd 19 48 to June 26 19 48 and that I last saw him alive on June 25 19 48

Immediate cause of death carcinoma colon - metastases to lung and brain

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

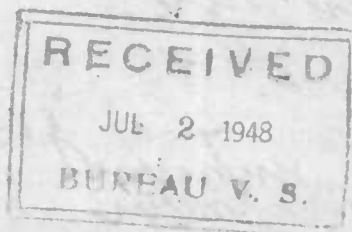
23. SIGNATURE Smith H. Wilson, M.D.
M. D. or other

Address Catheter, Md. Date signed 6/29/48

MARGIN RESERVED FOR BINDING

VS A15 9145-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITHOUT FADING INK. Supply every item of information carefully. Do not correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *28*

1. PLACE OF DEATH:

County *Queen Anne's*City or town *Crownsville*
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? *31 days*

Hospital, institution, or street address where death occurred:

*Crownsville State Hospital*How long in hospital or institution? *31 days*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md* CountyCity or town *Baltimore*
(If outside city or town limits, write RURAL and give nearest town)Street No. *1002 NE Durham St*
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

William Little

3.(b) Social Security Number

4. Sex

male

5. Color or race

negro

6.(a) Single, married, widowed, or divorced

single

B.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *April 7 1882*

8. AGE:

Years

Months

Days

If less than one day

*66**1**22*

hrs.

min.

9. Birthplace

Maryland
(Town, county, and state)

10. Usual occupation

farmer

11. Industry or business

MOTHER

12. Name

Wyatt Little

13. Birthplace

NW Carolina

14. Maiden name

Julia Phelps

15. Birthplace

NW Carolina

16. Informant

Hospital records

Address

Crownsville Md

17.

Burial
(Burial, cremation, or removal. Which?)

Date thereof

6 9 48
(month) (day) (year)

Cemetery or crematory

Unknown

Location

Mt. Calvary Cemetery

18. Funeral

Mrs. R. A. Ellist & Daughter

Address

1129 N. Caroline St.

19.

June 8 19 48
(Date rec'd by registrar)*A. W. Hedrick*

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *June 5 19 48* at *3 P M*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 5 19 48 to *June 5 19 48*and that I last saw him alive on *June 5 19 48*

Immediate cause of death

Chronic myocarditis

DURATION

known

Due to

to no

Due to

such

Other conditions

*Involuntarily psychosis**May 5 19 48*

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Jacob H. Hays

M. D. or other

Address

Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

5827

1. PLACE OF DEATH:

County... Anne Arundel
 City or town... Crownsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 mos.
 Hospital, institution, or street address where death occurred:
Crownsville State Hospital
 How long in hospital or institution? 2 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County.....
 City or town... Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1935 Chase St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

JOHN MARSHALL

3. (b) Social Security Number

4. Sex male 5. Color or race negro 6.(a) Single, married, widowed, or divorced unknown
 6.(b) Name of husband or wife ---
 7. Birth date of deceased (mo., day, yr.) 1866 6.(c) If alive, give age..... years
 8. AGE: Years 82 Months..... Days..... If less than one day..... hrs. min.

9. Birthplace... Maryland
 (Town, county, and state)
 10. Usual occupation... unknown
 11. Industry or business ----
 12. Name Ned Marshall (deceased)
 13. Birthplace Virginia
 14. Maiden name... Flora Marshall (deceased)
 15. Birthplace Virginia

16. Informant... Hospital Records
Crownsville, Md.

17. Burial Date thereof June 18/1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory mt carroll
 Location amph amundel co
 18. Funeral director Mrs. A. E. Ellis & Son, Inc.
 Address 1129 N. Caroline St
 19. June 18 48 Date rec'd by registrar June 18 48 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... June 15 19 48 at 1:45 a.m.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19 19 48 to June 15 19 48
 and that I last saw him alive on June 15 19 48
 Immediate cause of death Cerebral Arteriosclerosis
Known to us since 4/19/48

Due to.....
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?.....
 23. SIGNATURE Jacob M. M. M. M. M. M. D. or other.....
 Address Crownsville, Md. Date signed 6/15/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH:

County Anne Arundel
 City or town near Mayo. (Trin Beach)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? about one hour
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Prince George
 City or town Capital Heights
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 806 Capital Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war. ☒

3. (a) FULL NAME

Igilio Mattara

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Jan 18 1929

6. (c) If alive, give age years

8. AGE:

19

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Naples Italy
(Town, county, and state)

10. Usual occupation

Student + Barber

11. Industry or business

FATHER

12. Name

Silvino Mattara

13. Birthplace

Italy

MOTHER

14. Maiden name

Mattara

15. Birthplace

Italy

16. Informant

Attilio Mattara

Address

806 H 9th Ave Capital Heights

17.

(Hospital, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Removal to Lee Funeral Home

Location

18. Funeral director

J. Han Lee Sons Co.

Address

300-4th St. N.E.Washington, D.C.

19.

(Date rec'd by registrar)

June 17 1948J. B. Dent

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 17 1948 at 1:00 P.M.

21. I CERTIFY that death occurred on the date above stated, was attended by

Portsmouth Examination
and that I last saw him alive on June 17 1948

Immediate cause of death

Drowning

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 6-17-48

Where did injury occur?

MayoA.A.Md

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

drowning

Injured at work?

no

23. SIGNATURE

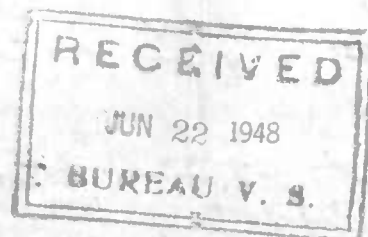
John M. Caffey M.D.Deputy Medical Examiner

Address

Annapolis, Md

Date signed

6-17-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: Anne Arundel
 County.....
 City or town..... Crownsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 mos 17 days
 Hospital, institution, or street address where death occurred:
Crownsville State Hospital
 How long in hospital or institution? 2 mos. 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... Maryland County.....
 City or town..... Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 1614 West Lexington
 (If rural, give LOCATION)

3. (a) FULL NAME
MARY McGEE

3. (b) Social Security Number

4. Sex FEMALE 5. Color or race NEGRO 6. (a) Single, married, widowed, or divorced WIDOW
 6. (b) Name of husband or wife --- unknown
 6. (c) If alive, give age 18 3/8 years
 7. Birth date of deceased (mo., day, yr.) Approximately 20 yrs. old
 8. AGE: Years 70? Months Days If less than one day
 hrs. min.

9. Birthplace Richmond, Virginia
 (Town, county, and state)
 10. Usual occupation None
 11. Industry or business
 12. Name Princeton Johnson
 13. Birthplace Virginia
 14. Maiden name Sarah Johnson
 15. Birthplace Virginia

16. Informant Hospital Records
 Address Crownsville, Md.
 17. burial Date thereof 6/26/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Mt. Auburn Cemetery
 Location Baltimore, Md.
 18. Funeral director Mrs. Katie R. Williams
 Address 222 N. Schroeder St.
 19. 6/26 19 48 Dr. Hedrick
 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 19 48 at 2:15 a.m.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 6 19 48 to June 23 19 48
 and that I last saw h. er alive on June 23 19 48

Immediate cause of death Chronic Myocarditis
Known to us since

Due to
 Due to

Other conditions Senile Psychosis
known to us since
 (Include pregnancy within 8 months of death)

Major findings of operations
 Date of op.
 Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Jacob M. Mays
 M.D. or other
 Address Crownsville, Md. Date signed 6/23/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1948
20
1878

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

5830

186a

1. PLACE OF DEATH:

County a a
 City or town Bay Ridge
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 hours
 Hospital, institution, or street address where death occurred:
Chesapeake Bay
 How long in hospital or institution:

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State New York County Westchester
 City or town Rye
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 265 - Grace Church
 (If rural, give LOCATION)
 2.(a) If veteran, name war:

3. (a) FULL NAME

Edward P. McGuire

3. (b) Social Security Number

123-01-0389

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Single
 6.(b) Name of husband or wife:
 7. Birth date of deceased (mo., day, yr.) March 3 - 1920
 6.(c) If alive, give age _____ years
 8. AGE: Years 28 Months 3 Days 24 If less than one day _____ hrs. _____ min.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 1948 at 7:45 P.M.

21. I CERTIFY that death occurred on the date above stated; Post mortem Examination
June 27 1948

Immediate cause of death Fracture of neck
 DURATION Sudden

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following: 6-27-48
 Accident, suicide, or homicide accident Date of _____

Where did injury occur? Bay Ridge N.Y. Manhasset Neck
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Chesapeake Bay

Means of injury Diving into shallow water Injured at work? no

23. SIGNATURE John N. Coffey M.D. DeputyAddress Amagansett, N.Y. ExaminerDate signed 6-28-4819. June 28 1948 Registrar

(Date rec'd by registrar)

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 29 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 5831

1. PLACE OF DEATH:

County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Emergency Hospital
How long in hospital or institution? 2 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town nr Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 334 Locust Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

ALDRICH R. MEER

3. (b) Social Security Number

214-14-4254

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Edith P. Meer 6.(c) If alive, give age 53 years
7. Birth date of deceased (mo., day, yr.) August 14, 1892
8. AGE: Years 55 Months 9 Days 19 If less than one day
.....hrs.min.

9. Birthplace Indiana
(Town, county, and state)
10. Usual occupation Night Watchman
11. Industry or business Meridith Ross Lumber Co.

FATHER 12. Name Henry B. Meer
13. Birthplace Germany

MOTHER 14. Maiden name Rebecca Jane Newton
15. Birthplace Prescott Indiana

16. Informant Mr. Richard H Meer (Son)
Address 334 Locust Ave. Annapolis, Md.

17. Burial Date thereof 6-5-48
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory St Anne's Cemetery
Location Annapolis, Maryland

18. Funeral director Ben L. Hoping and Son
Address 170-72 West St. Annapolis, Md.

19. June 4, 1948
(Date rec'd by registrar) Registrar W. F. French

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 June 1948 at 11:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1946 to 3 June 1948
and that I last saw him alive on 30 May 1948

Immediate cause of death Abdominal Distention DURATION 10 days

Due to Prolapse of sigmoid colon

Due to amputation left thigh 2 wks

Other conditions Myxochondroma left knee
(Include pregnancy within 8 months of death)

Major findings of operations
Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. F. French M.D.
M. D. or other
Address Medical Art. Baltimore Date signed 3 June 48

MARGIN RESERVED FOR BINDING

I

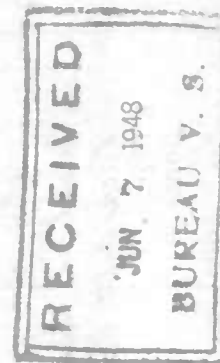
VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

abdominal dist^{en}ension? Paralytic ileus, post operative, & Peritonitis
Amputation left thigh

Myxo

left knee



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

48a

5832

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel
 City or town Annapolis
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 53 yrs
 Hospital, institution, or street address where death occurred:
334 Locust Ave.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel
 City or town Annapolis
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 334 Locust Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.

3. (a) FULL NAME

Edith Pearl (Morris) Meer

3. (b) Social Security Number

214-05-2534

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife Aldrich R. Meer
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Feb. 25, 1895
 8. AGE: Years 53 Months 3 Days 25 It less than one day _____ hrs. _____ min

9. Birthplace Annapolis, Maryland
 (Town, county, and state)
 10. Usual occupation Saleslady
 11. Industry or business Carlson's Bakery, Annapolis, Md.
 12. Name William W. Morris
 13. Birthplace Maryland

MOTHER
 14. Maiden name Sade Myers
 15. Birthplace Maryland

16. Informant Mr. Richard H. Meer
 Address 334 Locust Ave. Annapolis, Md.
 17. Burial Date thereof 6-24-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory St. Anne's, Cemetery
 Location Annapolis, Md.

18. Funeral director Ben L. Hopping and Son
 Address 170-172 West St. Annapolis, Md.

19. June 21 19 48
 (Date rec'd by registrar) Registrar J. F. Drinch

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20 19 48 at 8:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 11, 1947 to June 20, 1948
 and that I last saw him alive on June 20, 1948

Immediate cause of death Generalized Metastases
 DURATION Sync 7/4/47

Due to Carcinoma of the Cervix
 Due to of the uterus Sync 7/4/47

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operation Carcinoma of the Cervix
of the uterus Date of op. 10/20/48

Autopsy results _____

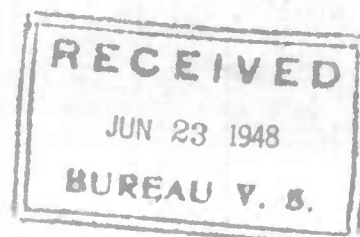
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Albert H. Anderson M.D.Address Annapolis, Md. Date signed 6/27/48



RECEIVED

JUN 23 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel
City or town Glen Burnie Heights
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel
City or town Glen Burnie
(If outside city or town limits, write RURAL and give nearest town)
Street No. Wilson Blvd.
(If rural, give LOCATION)
2(a) If veteran, name war

3. (a) FULL NAME

ANNIE MIDDLEBROOKS

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Harry Middlebrooks
7. Birth date of deceased (mo., day, yr.) May 11, 1891
8. AGE: Years 57 Months 1 Days 11 It less than one day 47 years
.....hrs.min.

9. Birthplace Caroline, County, Virginia
(Town, county, and state)
10. Usual occupation Housework
11. Industry or business Own Home
FATHER 12. Name John Collins
13. Birthplace Caroline County, Virginia
MOTHER 14. Maiden name Ester Prince
15. Birthplace Caroline County, Virginia

16. Informant Harry Middlebrooks
Address Glen Burnie, Md.

17. Burial June 25, 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Glen Haven
Glen Burnie, Md.
Location

18. Funeral director Thomas W. Singleton
Address Glen Burnie, Md.

19. 6/25 19 48 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22 1948 at 10.45p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/22 1948 to 6/22/48
and that I last saw her alive on 6/22/48 1948

Immediate cause of death Acute Myocardial Infarction
DURATION 3 years

Due to Hypertension 37.
Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. H. Parker M. D. or other
Address Glen Burnie, Md. Date signed 6/24/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 28 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

 5834
 159
 Reg. Dist. No. 27

1. PLACE OF DEATH:

County Anne Arundel
 City or town Fort Geo G. Meade
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 26 days
 Hospital, institution, or street address where death occurred:
Station Hospital Fort Geo G. Meade, Md.
 How long in hospital or institution? 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Anne Arundel
 City or town Fort George G. Meade, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. -
 (If rural, give LOCATION)
 2. (a) If veteran, name war -

3. (a) FULL NAME

KAREN SUE MORGAN

3. (b) Social Security Number

- -

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced -
 6. (b) Name of husband or wife -
 7. Birth date of deceased (mo., day, yr.) May 26, 1948
 8. AGE: Years - Months - Days 26 If less than one day - hrs. - min.

9. Birthplace Fort George G. Meade, Maryland
 (Town, county, and state)
 10. Usual occupation -
 11. Industry or business -
 12. Name Lawrence Wallace Morgan
 13. Birthplace Seattle, Washington
 14. Maiden name Edith Louise Patton
 15. Birthplace Grants Pass, Oregon

16. Informant Lawrence W. Morgan
 Address Fort Geo G. Meade, Md.
 17. Burial Date thereof June 25 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Post Cemetery
 Location Fort Geo G. Meade, Md.
 18. Funeral director DeWitt Donaldson
 Address Laurel, Maryland
 19. 23 June 48
 (Date rec'd by registrar) JAMES N. GOERGER CAPTAINS

MEDICAL CERTIFICATION

20. DATE OF DEATH 22 June 19 48 at 2150 hr

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 26 May 19 48 to 22 June 19 48
 and that I last saw him or alive on 22 June 19 48
 Immediate cause of death Prematurity

DURATION
26 days

Due to Premature birth (at 7 mo)
 Due to -
 Other conditions -

(Include pregnancy within 3 months of death)

Major findings of operations None
 Autopsy results 3 Pulmonary Abscesses
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide - Date of -
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) -
 Means of Injury Injured at work?

23. SIGNATURE David R. Medley M.D.
 Address Fort Meade Station
 Date signed 23 June 48

MASSACHUSETTS STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

RECEIVED
JUN 25 1948
BUREAU V. S.

VS A15

1 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is one important. Physicians: please write the causes of death clearly and legibly.

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Anne Arundel

City or town Rural, Nutwell, Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 1/2 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Q. Q. Co

City or town Rural, Nutwell, Md
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2 miles South on Fender Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war.

3.(a) FULL NAME

Thomas Wesley Mullen

4. Sex M 5. Color or race C 6.(a) Single, married, widowed, or divorced widowed

6.(b) Name of husband or wife Jeanette Mullen

7. Birth date of deceased (mo., day, yr.) July 8, 1874

8. AGE: Years 73 Months 10 Days 29 If less than one day

9. Birthplace Q. Q. Co
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name Thomas Mullen

13. Birthplace Nutwell, Md

14. Maiden name Unknown

15. Birthplace Id

16. Informant Henry F. Jefferson

Address 3515 Florida Ave. N.W.

17. Demis Date thereof 6/9/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematorium Friendship

Location A. C. Hardaway Dr

18. Funeral director J. C. Hardaway

Address Jaloville

19. 6/9 48 Registrar W. Clayton

(Date rec'd by registrar)

3.(b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6 19 48 at 5:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 26 May 19 48 to 6 June 19 48

and that I last saw h. l. m. alive on 6 June 19 48

Immediate cause of death arteriosclerosis

severe generalized

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE Robert B. Parker M. D. 6 June 48

Address upper Marlboro Md Date signed 6 June 48

RECEIVED

JUN 11 1948

BUREAU V. S.

Dr. Claffy

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 2/

1. PLACE OF DEATH:

County..... Anna Arundel
 City or town..... Annapolis
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Emergency Hospital
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Anne Arundel
 City or town..... Birdsville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

m SARAH E. NEESE

3. (b) Social Security Number

4. Sex..... Female
 5. Color or race..... White
 6. (a) Single, married, widowed, or divorced..... Married
 6. (b) Name of husband or wife..... John J. Neese
 6. (c) If alive, give age..... 76 years
 7. Birth date of deceased (mo., day, yr.)..... March 3, 1870

8. AGE: Years..... 77 Months..... 3 Days..... 15 hrs..... min.
 9. Birthplace..... Tennessee
 (Town, county, and state)

10. Usual occupation..... House wife
 11. Industry or business.....

12. Name..... James A. Dutton
 13. Birthplace..... Tenn.

14. Maiden name..... Adaline O. Estes
 15. Birthplace..... Tenn.

16. Informant..... Mr John L. Neese
 Address..... Harwood A.A. Co. Maryland

17. Burial..... June 21, 1948
 (Burial, cremation, or removal. Which?) Date thereof.....
 (month) (day) (year)
 Cemetery or crematory..... Fort Lincoln Cemetery
 Location..... Cottage City, Maryland

18. Funeral director..... Ben L. Hoping and Son
 Address..... 170-172 West St. Annapolis, Md.

19. June 21, 1948
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 18, 1948 at 12:17 A.M.

21. I CERTIFY that death occurred on the date above stated, Postmortem Examination
June 18, 1948

Immediate cause of death.....
Acute Cardiac Failure
 Due to..... Arterial Hypertension
Arterio-sclerosis
 Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?.....
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury..... Injured at work?.....
 23. SIGNATURE..... John M. Claffy, M.D.
Annapolis, Md.
 Address..... Date signed..... 6-18-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 23 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County H. A.
 City or town Carleigh Heights
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Garriel O Pendell

3. (b) Social Security Number

4. Sex

Female

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

Robert Pendell

7. Birth date of deceased (mo., day, yr.)

Sept 10 1867

6. (c) If alive, give age years

8. AGE:

80 years 9 months 16 days

9. Birthplace

Int. Tabl. H. & Co.
(Town, county, and state)

10. Usual occupation

Midwife

11. Industry or business

Isaac Brown

12. Name

Ind

13. Birthplace

Sallie Brown

14. Maiden name

Ind

15. Birthplace

Jessie Branch

16. Informant

3411 Puget St, Balto Ind

17. Burial

Bureau

18. Cemetery or crematory

Greening Park

19. Location

J. B. Johnson

20. Funeral director

Annapolis Ind

21. Address

4/28

22. Date

4/28

23. Registrar

L. O. Allen

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infant, give residence of mother)
 State Ind County H. A.
 City or town Carleigh Heights
 (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 26 1948 3:15 A.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 25 1948 to June 25 1948and that I last saw him alive on June 25 1948

Immediate cause of death

Cerebral hemorrhage

DURATION

2-3 days

Due to

Ischemic heart disease

Died of

Chronic Intoxicated

Died of

Hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

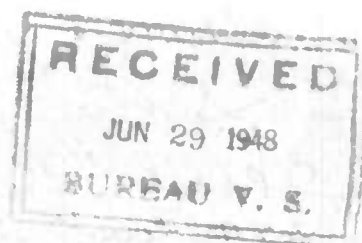
Injured at work?

23. SIGNATURE

John F. Alexander

M. D. or other

Address Flav. B. B. B. Ind Date signed 6/28/48



RECEIVED

JUN 29 1948

BUREAU V. S.

Dr. Linhardt

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5838

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel

City or town Annapolis
(If outside city or town limit, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Annapolis
(If outside city or town limit, write RURAL and give nearest town)Street No. 1205 West
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Charles L. Perry

3. (b) Social Security Number

4. Sex

Male

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Roberta E. Perry

7. Birth date of

deceased (mo., day, yr.)

6. (c) If alive, give age

years

Garry 26 1889

8. AGE:

Years 59

Months 4

Days 13

If less than one day

hrs. min.

9. Birthplace

G. A. Co. Md.

(Town, county, and state)

10. Usual occupation

Carpenter U.S.N.A.

11. Industry or business

Retired

12. Name

William E. Perry

13. Birthplace

G. A. Co. Md.

14. Maiden name

Alice Crandall

15. Birthplace

G. A. Co. Md.

16. Informant

Mrs. Gardner D. Greer

Address 1205 West St. Annapolis, Md.

17. (Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Burial

Cemetery or crematory

St. James Cemetery

Location

Anne Arundel Co. Md.

18. Funeral director

John W. Taylor, Inc.

Address

Annapolis, Md.

19. June 10 1948

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8 - 48 19 at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 12 1948, to June 8 1948

and that I last saw him alive on June 8 1948

Immediate cause of death

Hypertensive cerebrovascular disease -

Cerebral thrombosis, failure

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address Annapolis, Md.

M. D. or other

Date signed 6/10/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-5M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 11 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anna Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
14 Jefferson St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 14 Jefferson St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

JULIUS PHIPPS

3. (b) Social Security Number

4. Sex Male
5. Color or race White
6. (a) Single, married, widowed, or divorced Widowed
6. (b) Name of husband or wife Rachel Phipps
6. (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 18, 1861
8. AGE: Years 87 Months 2 Days 18 If less than one day hrs. min.

9. Birthplace Chalk Point, A.A. Co. Maryland
(Town, county, and state)
10. Usual occupation Ret. Capt. Sailing Merchant
11. Industry or business
12. Name Nicholas Phipps
13. Birthplace Maryland
14. Maiden name Gracie Ford
15. Birthplace Maryland

16. Informant Louis N. Phipps
Address College Ave. Annapolis, Maryland
17. Burial Burial Date thereof June 8, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory St. James Cemetery
Location Tracy's Landing A.A. Co. Maryland
18. Funeral director Ben L. Hopping and Son
Address 170-172 West St. Annapolis, Maryland
19. June 8, 48
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6, 1948 at 7:04 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1946 to June 6, 1948
and that I last saw him alive on June 6, 1948

Immediate cause of death Coronary Thrombosis
Due to Arteriosclerosis - Cardio - Vascular Disease
Other conditions 291
(Include pregnancy within 3 months of death)

Major findings of operations Arteriosclerosis - Cardio - Vascular Disease
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE Albert P. Anderson MD.
M. D. or other
Address Unsubscribed Date signed 6/8/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 9 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH: Anne Arundel
County.....
City or town.....
Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs. 3 mos. 12 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 2 yrs. 3 mos. 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... Maryland County..... Baltimore
City or town..... Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No..... 1717 W. Lexington St.
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME BENJAMIN SCHROEDER

3. (b) Social Security Number

4. Sex male 5. Color or race negro 6. (a) Single, married, widowed, or divorced widowed
6. (b) Name of husband or wife.....
7. Birth date of deceased (mo., day, yr.) 12/20/1866 6. (c) If alive, give age..... years
8. AGE: Years 81 Months Days It less than one day
..... hrs. min.

9. Birthplace..... unknown
(Town, county, and state)
10. Usual occupation..... unknown
11. Industry or business.....
12. Name..... unknown
13. Birthplace..... unknown
14. Maiden name..... unknown
15. Birthplace.....

16. Informant..... Hospital Records
Address..... Crownsville, Md.
17. Date thereof..... June 21, 1948
(Burial, cremation, or removal, which?)
Cemetery or crematorium..... Mt. Zion June 21, 1948
Location..... Lonsdale Baltimore to Md.
18. Funeral director..... Mrs. Kate R. Williams
Address..... 322 N. Schroeder St.
6/21. 48 E. F. Joyce Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 18 1948 at 6:30 a.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 6 1946 to June 18 1948
and that I last saw him alive on June 18 1948
Immediate cause of death..... Cerebral Arteriosclerosis DURATION March 1948
known to us since
Due to.....
Due to.....
Other conditions..... Senile Psychosis known to us since 3/6/46
(Include pregnancy within 3 months of death)
Major findings of operations.....
Date of op.....
Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur?..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?).....
Means of injury..... Injured at work?.....
23. SIGNATURE..... Jacob M. Weinstein M.D.
Address..... Crownsville, Md. Date signed 6/18/48

RECEIVED

JUN 25 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

5841

Reg. Dist. No. 28

1. PLACE OF DEATH:

County Anne Arundel
 City or town Crownsville, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 months, 27 days
 Hospital, institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.
 How long in hospital or institution? 2 months, 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 422 Burgundy
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____ ✓

3. (a) FULL NAME

ALLEN SIMMONS

3. (b) Social Security Number

4. Sex Male 5. Color or race Negro 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife unknown
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) 1900
 8. AGE: Years 48 Months ? Days ? If less than one day _____ hrs. _____ min.

9. Birthplace South Carolina
 (Town, county, and state)
 10. Usual occupation Laborer
 11. Industry or business _____
 12. Name Mackay Simmons
 13. Birthplace South Carolina
 14. Maiden name Aurelia Grant
 15. Birthplace South Carolina

16. Informant Hospital Records
 Address Crownsville, Maryland
 17. Cremial Date thereof 7/9-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Hastings
 Location Crownsville Ind
 18. Funeral director Dupst
 Address Crownsville Ind
 19. 7/9-48 E. F. Joyce
 (Date registered by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27th 1948 at 11:30A M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 30th 48 to June 27th 1948
 and that I last saw him alive on June 27th 1948
 Immediate cause of death General Paresis Known to us since 3/30/48
 Due to _____
 Due to _____
 Other conditions General Paresis known to us since 3/30/48
 (Include pregnancy within 3 months of death)
 Major findings of operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE Dr. J. H. H. H. H. H. M. D. or other _____
Crownsville, Maryland Date signed 6/27/48

RECEIVED

JUL 12 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Anne ArundelCity or town Crownsville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 23 yrs. 3 daysHospital, institution, or street address where death occurred:
Crownsville State HospitalHow long in hospital or institution? 23 yrs. 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

JOHN HENRY SIMMS JR.

3. (b) Social Security Number

4. Sex <u>male</u>	5. Color or race <u>negro</u>	6.(a) Single, married, widowed, or divorced <u>married</u>
-----------------------	----------------------------------	---

6.(b) Name of husband or wife Cora Simms7. Birth date of deceased (mo., day, yr.) 1899?8. AGE: Years Months Days If less than one day
49? hrs. min.9. Birthplace Maryland
(Town, county, and state)10. Usual occupation Laborer

11. Industry or business

12. Name John Simms13. Birthplace Maryland14. Maiden name Hester Fall15. Birthplace Maryland16. Informant Hospital recordsAddress Crownsville, Md.17. Burial Date thereof 6 9 48
(Burial, cremation, or reprobation. Which?) (month) (day) (year)Cemetery or crematory East Union CemeteryLocation Balto, Md18. Funeral director Mrs. Katie R. WilliamsAddress 322 N. Schuylker St19. 6-6-49 E. F. Joyce Local
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5, 19 48, at 8:45 A.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
June 8, 19 25, to June 5, 19 48
and that I last saw him alive on June 5, 19 48

Immediate cause of death <u>Cerebral Hemorrhage</u>	DURATION
Patient known to us since	<u>6/8/25</u>
Due to <u>Previous Stroke on</u>	<u>2/13/46</u>

Due to

Other conditions Dementia Praecox

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Jacob Morgeustum M.D.Address Crownsville, Md.Date signed 6/5/48

RECEIVED
JUN 8 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne ArundelCity or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

133 Monticello Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County A. A. Co.City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)Street No. 133 Monticello Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Jesse J. Simpson

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Greene E. Simpson

7. Birth date of

deceased (mo., day, yr.)

Oct 15th 1891

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

46722

hrs.

min.

9. Birthplace

New York
(Town, county, and state)

10. Usual occupation

Electrical Contractor

11. Industry or business

12. Name James Simpson13. Birthplace New York14. Maiden name Mary Campbell15. Birthplace New York16. Informant Miss Olive SimpsonAddress 133 Monticello Ave. Annapolis

17. Burial, cremation, or removal. Which?

Burial Date thereof June 9th 48
(month) (day) (year)Cemetery or crematory All HallowsLocation Davidsonville Md.18. Funeral director John M. Taylor & SonAddress Annapolis Md.19. June 8 48
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6, 1948 at 3:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 1942 to 6-6-1948and that I last saw him alive on 6-6-1948

Immediate cause of death

Carcinomatosis

DURATION

2 yrs.Due to Carcinoma of Prostate6 yrs.

Due to

CachexiaHypertensive Cardiovascular DiseaseOther conditions 13 yrs.18 yrs.(Include pregnancy within 3 months of death) Dissecting

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James R. Martin, M.D.
M. D. or otherAddress Annapolis, Md. Date signed 6-7-48

RECEIVED

JUN 9 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

5844

1. PLACE OF DEATH:

County D. A. C. Co. Md.
 City or town Edgewater, Adams
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Catherine N. Smith

3. (b) Social Security Number

4. Sex F 5. Color or race N. Negro 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife

John Smith

7. Birth date of deceased (mo., day, yr.)

2/7/1878

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

70 4 14 hrs. min.

9. Birthplace

Baltimore Md.
(Town, county, and State)

10. Usual occupation

Housewife

11. Industry or business

MOTHER

FATHER

12. Name

Michael J. Raude

13. Birthplace

Ireland

14. Maiden name

Mary Hawke

15. Birthplace

Ireland

16. Informant

M. J. Smith

Address

1513 Battery Ave

17. Burial

(Burial, cremation, or removal, Where?)

Date thereof

6/25/48
(month) (day) (year)

Cemetery or crematory

Catharine Cem

Location

Red Frederick Road

18. Funeral director

J. J. Foley

Address

1318 Light St

19.

6/28
(month) (day) (year)

19.

48
(month) (day) (year)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltimoreCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 1513 Battery Ave
(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27th 1948 at 2:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended/deceased from

May 1st 1941 to 6/22/48and that I last saw her alive on 6/21/48

Immediate cause of death

sclerotic heart disease

DURATION

2

Due to

Due to

Other conditions

None

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Harry Deibel, M.D.

M. D. or other

Address 1226 Hanover St.Date signed 6/23/48

Deibel

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

5845

Reg. Dist. No. 20

1. PLACE OF DEATH:
County... Living, Beach, A. A. Co.
City or town... Living, Beach, Ind.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, institution, or street address where death occurred:
no
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State... D. C. County... —
City or town... Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1400 - Pa. Ave. S.E.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME
Bert A. Smyser

3.(b) Social Security Number
none

4. Sex male. 5. Color or race white 6.(a) Single, married, widowed, or divorced married
6.(b) Name of husband or wife Lyla Mae Kelly
7. Birth date of deceased (mo., day, yr.) May 14, 1874
8. AGE: Years 74 Months 1 Days 8 If less than one day — hrs. — min.

9. Birthplace Ynk. Penna.
(Town, county, and state)
10. Usual occupation pharmacist
11. Industry or business Drug store
12. Name Edward Smyser
13. Birthplace Ynk. Pa.
14. Maiden name —
15. Birthplace Ynk. Pa.

16. Informant Lyla Mae Smyser
Address 1400 - Pa. Ave S.E.
17. Burial Date thereof June 24, 1948
(Burial, cremation, or removal Which?) (month) (day) (year)
Cemetery or crematory Edgar Kelly
Location Suitland, Md.

18. Funeral director William Lee Co
Address 3074th St. N.E.
6/22 48
19. (Date rec'd by registrar) 19 6/22 48 Registrar W. J. Clayton

MEDICAL CERTIFICATION

20. DATE OF DEATH Living, Beach June 24 19 48 at 4:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from not at all 19 48 to June 24 19 48
and that I last saw him alive on not at all 19 48
Immediate cause of death central hemorrhage
Due to hypertension
arteriosclerosis
Due to —
Other conditions —
(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —

Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

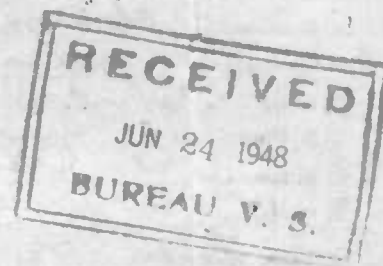
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work? —

23. SIGNATURE Emil H. Wilcox, M.D.
Address Cottman, Md. Date signed 6/22/48

MARGIN RESERVED FOR BINDING

VS A15 T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Prince Georges County

City or town Annapolis, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since April 23, 1948.

Hospital, institution, or street address where death occurred Emergency Hospital, Annapolis, Md.

How long in hospital or institution? Since April 23, 1948.

3. (a) FULL NAME

Dorothy Stockhausen

4. Sex

F.

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Carl Stockhausen

Married, 1914

6. (c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.)

May 12, 1914

8. AGE:

Years 34 Months 26 Days 26 It less than one day

9. Birthplace

Baltimore, Md.

10. Usual occupation

Housewife

11. Industry or business

HERBERT L. NORFOLK

12. Name

John Norfolk

13. Birthplace

Baltimore

14. Maiden name

Rutha Cooper

15. Birthplace

Balto., Md.

16. Informant

Carl Stockhausen

17. Address

Manhattan Beach, Md.

18. Burial

Date thereof 6/11/48

19. Cemetery or crematory

Western Balto., Md.

20. Location

William Cook, Inc.

21. Funeral director

Address 1257 St. Paul St.

22. Date

June 10, 1948

23. Signature

A. W. Hedrick

24. Registrar

Date signed 6/17/48

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For those whom infants give residence of mother)

State Maryland County G. A. C.

City or town F. A. C.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH June 7, 1948, at 7:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1, 1947, to June 7, 1948

and that I last saw him alive on June 7, 1948

Immediate cause of death

Coronary of the Brain

Due to

Scurvy

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Albert R. Anderson, M.D.

Address

Annapolis, Md. Date signed 6/17/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 5847 - 21

1. PLACE OF DEATH:

County Anne Arundel CountyCity or town Brentwood Beach
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Anne ArundelCity or town Brentwood Beach
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)2.(a) If veteran, name war W.O.

3. (a) FULL NAME

JOHN ADEN SUMMERS

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widower

6. (b) Name of husband or wife

Mary A.

6. (c) If alive, give age _____ Years

7. Birth date of deceased (mo., day, yr.)

June 15, 1883

8. AGE:

Years

Months

Days

If less than one day

65-14

hrs.

min.

9. Birthplace

Baltimore, Md.
(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

FATHER

12. Name

Patience J. Summers

13. Birthplace

Deland

MOTHER

14. Maiden name

Betha Fawcett

15. Birthplace

Lavage, Md.

16. Informant

Summers

Address

Brentwood Beach, A.A. County

17.

(Burial, cremation, or removal. Which?)

Date thereof

7-7-48
(month) (day) (year)

Cemetery or crematory

Cathedral

Location

Baltimore

18. Funeral director

George A. Foley

Address

Fulton Ave. & Fayette St.

19.

(Date rec'd by registrar)

19

6/3048AWFriedrichDr

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 19 48 at 8:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 20 19 48 to June 29 19 48and that I last saw him alive on June 20 19 48Immediate cause of death Coronary Thrombosis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE

J. Brady Smith, M.D.

M. D. or other

Address Pickens Beach, Md. Date signed 6/29/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 5848 25

1. PLACE OF DEATH:

County Anne Arundel
 City or town Sarvey
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 30 years
 Hospital, institution, or street address where death occurred:
Forest Ave.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County A. A.
 City or town Sarvey
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Forest Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war No

3. (a) FULL NAME

Charles Wesley Tipton Jr.

3. (b) Social Security Number

718-14-9315

4. Sex M. 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Bladys Sarvey
 7. Birth date of deceased (mo., day, yr.) March 28 - 1908 6.(c) If alive, give age 39 years
 8. AGE: Years 40 Months 2 Days 14 If less than one day
hrs. min.

9. Birthplace Baltimore, Md.
 (Town, county, and state)

10. Usual occupation Electrician

11. Industry or business

FATHER 12. Name Charles H. Tipton, Sr.
 13. Birthplace Hanford County, Md.
 MOTHER 14. Maiden name Carrie Capelsang
 15. Birthplace Baltimore, Md.

16. Informant Mrs. C. W. Tipton, Sr. (mother)
 Address Sarvey, Md.

17. Burial Date thereof June 10 - 48
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Meadowridge
 Location Sarvey, Md.

18. Funeral director Harry H. Witke
 Address 4101 Edmondson Ave

19. 6/18 48 A-W 18
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12, 1948 at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 19... to 19...
 and that I last saw him... alive on... 19...

Immediate cause of death Coronary Occlusion DURATION Sudden

Due to...
 Due to...

Other conditions...
 (Include pregnancy within 3 months of death)

Major findings of operations... Date of op...

Autopsy results...
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide... Date of...
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Walter H. Fancher, M.D.
 Address 1515 E. 1st St., Baltimore, Md. Date signed 6/17/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 5850 20

1. PLACE OF DEATH:
 County..... **Anne Arundel**
 City or town..... **Lothian**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? **3 yrs.**
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... **Md.** County..... **A.A.**
 City or town..... **Lothian**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME **Annie Bell Turner** 3. (b) Social Security Number **none**

4. Sex **F** 5. Color or race **W** 6. (a) Single, married, widowed, or divorced **Widow**
 6. (b) Name of husband or wife **James William Turner**
 7. Birth date of deceased (mo., day, yr.) **Sept. 27, 1873** 6. (c) If alive, give age..... years
 8. AGE: Years **74** Months **3** Days **25** It less than one day..... hrs. min.

9. Birthplace..... **Calvert Co. Md**
 (Town, county, and state)
 10. Usual occupation..... **Housewife**
 11. Industry or business.....
 FATHER 12. Name..... **Richard M. Gibson**
 13. Birthplace..... **Calvert Co. Md.**
 MOTHER 14. Maiden name..... **Barbara Jane Catterton**
 15. Birthplace..... **Calvert Co. Md.**

16. Informant..... **Herman Turner**
 Address..... **Lothian, Md.**
 Burial
 17. (Burial, cremation, or removal. Which?) Date thereof..... **6/24/48**
 (month) (day) (year)
 Cemetery or crematory..... **Mt. Zion**
 Location..... **Lothian, Md.**
 18. Funeral director..... **T.A. Hardesty & Son**
 Address..... **Galesville, Md.**
 19. (Date rec'd by registrar)..... **6/24 48** Registrar.....

MEDICAL CERTIFICATION

20. DATE OF DEATH..... **June 21** 19 **48** at **12.55** P.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **March** 19 **48** to **June 21** 19 **48**
 and that I last saw him alive on **June 21** 19 **48**

Immediate cause of death..... **cerebral hemorrhage**
 Due to..... **arteriosclerosis**
 Due to..... **hypertension**
 Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.....
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

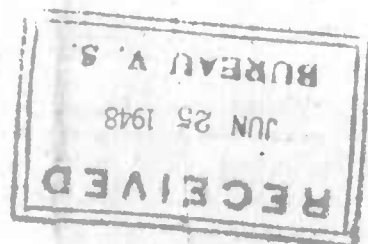
22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?

23. SIGNATURE..... **Emily H. Wilson, M.D.**
 Address..... **Lothian, Md.** Date signed..... **6/22/48**

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Evidence for addition of
birth date and change of
age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5851

Reg. Dist. No. 21
FILM No. G 116 JUN 18 1948 CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County... Annapolis Md.

City or town... Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

How long above place of death?

Hospital, institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Annapolis

City or town... Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 56 Southgate Ave

(If rural, give LOCATION)

2.(a) If veteran, name war...

3. (a) FULL NAME

Oscar Warmcastle

3. (b) Social Security Number

4. Sex

Male

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, year) Unknown 1875

6. (c) If alive, give age... years

8. AGE: Years... Months... Days... It less than one day... hrs... min.
About 72

9. Birthplace... Annapolis Md.
(Town, county, and state)

10. Usual occupation... none

11. Industry or business

12. Name... Unknown

13. Birthplace

14. Maiden name... Unknown

15. Birthplace

16. Informant... Record at Hospital
Annapolis Md.

Address... Bureau

17. Bureau Date thereof... June 14-48
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematorium... St. Mary's Cent

Location... Annapolis Md.

18. Funeral director... John W. Sayla, Son

Address... Annapolis Md.

19. June 14 48 W. D. Ormish
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... June 11 19 48 at 10 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 8 19 48 to June 11 19 48 and that I last saw him alive on June 11 19 48

Immediate cause of death... Coronary Thrombosis

Due to... Arteriosclerosis

Due to... Arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... George B. Paul

M. D. or other

Address... Annapolis Md. Date signed... 6-15-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 15 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex.....

5. Color or race.....

6. (a) Single, married, widowed, or divorced.....

6. (b) Name of husband or wife.....

7. Birth date of

deceased (mo., day, year).....

8. AGE:

Years.....

Months.....

Days.....

If less than one day

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

MOTHER

FATHER

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

18. Informant.....

Address.....

17. BURIAL

(Burial, cremation, or removal. Which?)

Date thereof.....

(month) (day) (year)

Cemetery or crematory.....

Location.....

19. Funeral director.....

Address.....

19.

(Date rec'd by registrar)

19. 48

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

June 28, 48

19.....

at 10A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 15 - 48 to June 28, 48

and that I last saw him alive on June 25 - 48

Immediate cause of death.....

DURATION

Due to.....

Due to.....

Other condition.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

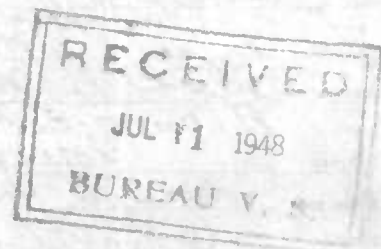
Means of injury.....

Injured at work?

23. SIGNATURE.....

M. D. or other

Address.....



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5853

CERTIFICATE OF DEATH

Reg. Dist. No. 2/

1. PLACE OF DEATH: Anne Arundel

County.....

City or town..... Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 Days

Hospital, institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution? 3 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Anne Arundel

City or town..... Parole, Md. near Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No..... Parole, Md. near Annapolis

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

James Alger Watkins

3. (b) Social Security Number

216-22-3404

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife.....

7. Birth date of

deceased (mo., day, yr.)

December 25, 1928

6. (c) If alive, give age..... years

8. AGE:

19

Years

Months

6

Days

2

If less than one day

..... hrs.

..... min.

9. Birthplace..... Parole, Md. Anne Arundel Co. Md.

(Town, county, and state)

10. Usual occupation..... Laborer

11. Industry or business

None

FATHER

12. Name..... Noble Watkins

13. Birthplace..... Annapolis, Md.

MOTHER

14. Maiden name..... Mammie Fisher

15. Birthplace..... Parole, Md.

16. Informant..... Noble Watkins

Address..... Parole, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof..... 6-30-1948

(month) (day) (year)

Cemetery or crematory..... Fowlers Chapel Cemetery

Location..... Best Gate, Md.

18. Funeral director..... Mrs. Charles E. Hicks

Address..... 43-45 Northwest Street

19. June 30, 1948

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

June 27, 1948 at 11:00 P.M.

21. I CERTIFY that death occurred on the date above stated; ~~that death was caused by~~

Post mortem Examination

June 27, 1948

Immediate cause of death.....

Intra-cerebral Hemorrhage

Due to.....

Severe concussion of Brain

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident

June 25, 1948

Accident, suicide, or homicide.....

Date of.....

Where did injury occur? Near Parole

(City or town)

A. P. Maryland

(County) (State)

Injured at home, farm, industry, public place (where?) Route 450

Means of injury Auto turned over

Injured at work? No

23. SIGNATURE.....

John M. Caffy M.D. Deputy Medical Examiner

Address.....

Annapolis, Maryland

Date signed 6-30-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

5854

62

1. PLACE OF DEATH:

County Anne Arundel

City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

U.S. Naval Hospital, Annapolis, Maryland

How long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Annapolis Route #2 Box 200
(If outside city or town limits, write RURAL and give nearest town)

Street No. Nr. Annapolis
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

WEBER, Mrs. Emma Emelie

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife August Weber-husband

6. (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Oct. 14, 1886

8. AGE:	Years	Months	Days	If less than one day
	<u>61</u>	<u>62</u>	<u>6</u>	<u>27</u>
			hrs.	min.

9. Birthplace Junction City, Kansas
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Augustus Cott

13. Birthplace Germany

14. Maiden name Forelick

15. Birthplace Germany

16. Informant Edwin Weber (son)

Address Route #2, Box 200, Annapolis, Maryland

17. Removal (Burial, cremation, or removal. Which?) Removal

Date thereof June 12, 1948
(month) (day) (year)

Cemetery or crematory To. Junction City, Kansas

Location To. Junction City, Kansas

18. Funeral director Ben L. Hopping and Son

Address 170-172 West St. Annapolis, Md.

19. June 12, 1948
(Date rec'd by registrar)

20. Signature [Signature]
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 June 1948 at 9:07 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 28 May 1948 to 11 June 1948

and that I last saw her alive on 11 June 1948

Immediate cause of death Circulatory Collapse

Other conditions

Due to Arteriosclerotic Heart Disease

Due to Advanced Pituitary Cachexia

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Consistent above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE G. M. Davis

G. M. DAVIS, CDR, MC, USN. M. D. or other

U.S. Naval Hospital, Annapolis, Md. 6-11-48

Address

Date signed

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 15 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

5855

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne ArundelCity or town Pasadena
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For born infant, give residence of mother)

State Maryland County Anne ArundelCity or town Pasadena P.O.
(If outside city or town limits, write RURAL and give nearest town)Street No. Boulevard Park
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Henry Weisenborn

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

none

7. Birth date of deceased (mo., day, yr.)

7-15-1875

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

721129

hrs.

min.

9. Birthplace

md.
town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

-

MOTHER FATHER

12. Name

Frank Weisenborn

13. Birthplace

Germany

14. Maiden name

Elizabeth Jughaus

15. Birthplace

Germany

16. Informant

Justus Weisenborn

Address

2903 Fair Ave.

17.

Burial

Date thereof

6-17-48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Oak Lawn

Location

Eastern Ave. Exp.

18. Funeral director

Lilya Zeiler Inc.

Address

403 S. Wolfe St.

19.

6/16 48

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MEDICAL CERTIFICATION

20. DATE OF DEATH

June 14 19 48 10¹⁰ A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Postmortem Examination
and that I last saw him June 14 19 48

Immediate cause of death

DURATION

Due to

Acute Cardiac Failure

Due to

Chronic Myocarditis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John M. Caffrey, M.D.
Annapolis, Md.
Date signed 6-14-48

Address

Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

5856

28

93d

1. PLACE OF DEATH:

County Anne Arundel
 City or town Crownsville, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 year, 3 months, 20 days
 Hospital, institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.
 How long in hospital or institution? 1 year, 3 months, 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Pr. Geo.
 City or town Marlboro
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

JOHN WELLS

3. (b) Social Security Number

4. Sex Male 5. Color or race Negro 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife
 6.(c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) 1877
 8. AGE: Years 71 Months ? Days ? If less than one day hrs. min.

9. Birthplace Maryland
 (Town, county, and state)
 10. Usual occupation Laborer
 11. Industry or business
 12. Name Smith Wells
 13. Birthplace Maryland
 14. Maiden name Mary Sparett
 15. Birthplace Maryland

16. Informant Hospital Records
 Address Crownsville, Maryland
 17. Burial Date thereof 7/7-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery St. Joseph's
 Location Crownsville, Md.
 18. Funeral director St. Joseph's Hospital
 Address Crownsville, Md.
 19. 7/7-48 19 48
 (Date rec'd by registrar) Registrar Ed Jones Local

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28th 19 48 at 12:45 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 8th 19 48 to June 28th 19 48and that I last saw him alive on June 28th 19 48

Immediate cause of death Chronic Myocarditis DURATION Known to us since 3-8-1947
 Other conditions Senile Psychosis- Known to us since 3-8-47
Paranoid Condition
 (Include pregnancy within 3 months of death)

Due to

Due to

Other conditions Senile Psychosis- Known to us since 3-8-47
Paranoid Condition
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Jacob M. Mays M. D. or otherAddress Crownsville, Maryland Date signed 6/28/48

1948
71
1877

RECEIVED

JUL 9 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County..... Anne Arundel
 City or town..... Sever
 (If outside city or town, limit or write RURAL and give nearest town)

How long in above place of death?
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

Female

5. Color or race

B

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

Leonard Williams

7. Birth date of

deceased (mo., day, yr.) October 25, 1871

6. (c) If alive, give age..... years

8. AGE:

76

Years

Months

Days

If less than one day

..... hrs.

min.

9. Birthplace

Howard County, Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

19. Date signed

19. Date signed

19. Date signed

19. Date signed

19. Date signed

19. Date signed

19. Date signed

19. Date signed

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md. County..... Anne ArundelCity or town..... Sever
(If outside city or town, limit or write RURAL and give nearest town)Street No..... Queenston Rd
(If rural, give LOCATION)

2. (a) If related, give relationship

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 27-48 19..... at..... 1 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 14 48 to June 27-48and that I last saw him/her alive on June 1-48 19.....

Immediate cause of death.....

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:

County Anne Arundel
City or town Del Rio Beach-Edgewater
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

John O. Worley

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Oct. 23rd. 1928

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

It less than one day

20

7

20

hrs.

min.

9. Birthplace

Maryland
(County, and state)

10. Usual occupation

Lithographer

11. Industry or business

Photoprocess Co. Balt.

FATHER

12. Name

Robert R. Worley

13. Birthplace

Maryland

MOTHER

14. Maiden name

Clara Fritz

15. Birthplace

Md.

16. Informant

Mr. Robert R. Worley

Address

1822 N. Montford Ave. Balto.

17. Burial

(Burial, cremation, or removal, Which)

Date thereof

(month) (day) (year)

Cemetery or crematory

Holy Redeemer

Location

Baltimore

18. Funeral director

Leo S. Cook

Address

1701-03 Patterson Pl. Ave.

19. June 12 48

(Date rec'd by registrar)

Edue and Collinson

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

City or town

Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.

1822 N. Montford Ave.
(If rural, give LOCATION)

2. (a) If veteran, name war.

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 12 1948 at 12 25 p.m.

21. I CERTIFY that death occurred on the date above stated: Postmortem Examination

Immediate cause of death

Drowning

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Accident

Date of

6-12-48

Where did injury occur?

Edgewater

(City or town)

A. H. Maryland

Injured at home, farm, industry, public place (where?)

Del Rio Beach

Means of injury

drowning

Injured at work?

No

23. SIGNATURE

John M. Claffy M.D.

Deputy Medical Examiner

Address

Annapolis Md.

Date signed

6-12-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

